

No. 98-536-CFX

Title: Tommy Olmstead, Commissioner, Georgia Department of Human Resources, et al., Petitioners v.

L. C., By Jonathan Zimring, Guardian Ad Litem and Next Friend, et al.

Docketed:

September 29, 1998

Court: United States Court of Appeals for the Eleventh Circuit

Entry Date

Proceedings and Orders

Sep 29 1998 Petition for writ of certiorari filed. (Response due October 29, 1998)

Oct 27 1998 Brief of respondent L.C., etc., et al. in opposition filed.

Oct 29 1998 Brief amici curiae of Florida, et al. filed.

Nov 9 1998 Reply brief of petitioners Tommy Olmstead, Commissioner, et al. filed.

Nov 10 1998 DISTRIBUTED. November 25, 1998

Nov 30 1998 REDISTRIBUTED. December 4, 1998

Dec 7 1998 REDISTRIBUTED. December 11, 1998

Dec 14 1998 Petition GRANTED.  
SET FOR ARGUMENT April 21, 1999.  
\*\*\*\*\*

Dec 17 1998 The order entered December 14, 1998, granting the petition is amended to read as follows: The petition for a writ of certiorari is granted limited to Question 1 presented by the petition.

Jan 7 1999 Order extending time to file brief of petitioner on the merits until February 4, 1999.

Jan 22 1999 Letter of petitioners requesting a further extension of time to file brief on the merits filed.

Jan 25 1999 Order DENYING petitioners request for a further extension of time to file the brief on the merits.

Feb 3 1999 Brief amici curiae of Voice of the Retarded, et al. filed.

Feb 4 1999 Brief amici curiae of National Conference of State Legislatures, et al. filed.

Feb 4 1999 Joint appendix filed.

Feb 4 1999 Brief of petitioners Tommy Olmstead, Commissioner, GA Dept. of Human Res., et al. filed.

Feb 4 1999 Brief amici curiae of Nevada, et al. filed.

Feb 11 1999 Letter from the Attorney General of Minnesota received and distributed.

Feb 19 1999 Brief amici curiae of ADAPT, National Council of Independent Living and TASH filed.

Feb 26 1999 Order extending time to file brief of respondent on the merits until March 15, 1999.

Mar 9 1999 Letter from the Attorney General of Washington received and distributed.

Mar 10 1999 Letter from the Attorney General of Massachusetts received and distributed.

Mar 12 1999 CIRCULATED.

Mar 12 1999 Brief amici curiae of American Psychiatric Association, et al. filed.

Mar 12 1999 Brief amicus curiae of National Council on Disability filed.

2 PP



Entry Date

## Proceedings and Orders

|             |  |
|-------------|--|
| Mar 15 1999 | Brief of respondents L.C., by Jonathan Zimring, Guardian Ad Litem, et al. filed.   |
| Mar 15 1999 | Brief amici curiae of People First of Georgia, et al. filed.   |
| Mar 15 1999 | Brief amici curiae of Dick Thornburgh and Natl. Organization on Disability filed.  |
| Mar 15 1999 | Brief amici curiae of American Civil Liberties Union, et al. filed.  |
| Mar 15 1999 | Brief amici curiae of American Association on Mental Retardation, et al. filed.  |
| Mar 15 1999 | Brief amici curiae of 58 Former State Commissioners, et al. filed.   |
| Mar 15 1999 | Brief amici curiae of Natl. Mental Health Consumers' Self-Help Clearinghouse, et al. filed.                              |
| Mar 15 1999 | Brief amicus curiae of United States filed.  |
| Mar 17 1999 | Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.   |
| Mar 22 1999 | Letter from Attorney General of Mississippi received and distributed.  |
| Mar 29 1999 | Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED. |
| Mar 30 1999 | Record filed.  |
| Apr 1 1999  | Letter from Attorney General of Indiana received and distributed.  |
| Apr 1 1999  | Letter from the Attorney General of Louisiana received and distributed.  |
| Apr 14 1999 | Reply brief of petitioner Tommy Olmstead, Commr., GA Dept. of Human Resources, et al. filed.                             |
| Apr 15 1999 | Letter from the Attorney General of South Carolina received and distributed  |
| Apr 21 1999 | ARGUED.  |

No. 1

98 536 SEP 29 1998

In The OFFICE OF THE CLERK  
**Supreme Court of the United States**  
October Term, 1997

TOMMY OLMSTEAD, Commissioner of the Department  
Of Human Resources of the State of Georgia,  
RONALD C. HOGAN, Superintendent of Georgia  
Regional Hospital/Atlanta, and EARNESTINE  
PITTMAN, Executive Director of the  
Fulton County Regional Board,

*Petitioners,*

v.

L.C. and E.W., each by JONATHAN ZIMRING  
as guardian ad litem and next friend,

*Respondents.*

On Petition For A Writ Of Certiorari  
To The United States Court Of Appeals  
For The Eleventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

Georgia provides for the treatment and habilitation of mentally disabled persons in two main types of residential settings: institutional facilities, and a wide range of settings called "community placements." The State's choice of setting for an individual requiring public care depends on the individual's mental condition, on the fact and extent of his dangerousness and inability to care for himself, and on fiscal and administrative considerations.

The questions presented are:

1. Whether the public-services portion of the federal Americans with Disabilities Act compels the State to provide treatment and habilitation for mentally disabled persons in a community placement, when appropriate treatment and habilitation can also be provided to them in a State mental institution.
2. If that portion of the Act is so construed, whether it exceeds the enforcement power granted to Congress in Section 5 of the Fourteenth Amendment.

## PARTIES BELOW

The parties to the proceedings in the Court of Appeals and in the District Court were as listed in the caption, except that pursuant to Rule 25(d) of the Federal Rules of Civil Procedure, Ronald C. Hogan has been automatically substituted for Richard Fields, due to Hogan's succeeding Fields as Superintendent of Georgia Regional Hospital at Atlanta.

## TABLE OF CONTENTS

|  | Page |
|--|------|
| QUESTIONS PRESENTED .....  | i    |
| PARTIES BELOW .....  | ii   |
| TABLE OF CONTENTS .....  | iii  |
| TABLE OF AUTHORITIES .....   | v    |
| OPINIONS BELOW .....   | 1    |
| JURISDICTION .....   | 1    |
| CONSTITUTIONAL AND STATUTORY PROVISIONS .....  | 2    |
| STATEMENT .....  | 2    |
| A. CLAIMS AND FACTS .....  | 2    |
| B. GEORGIA'S PROVISIONS FOR CARE .....   | 4    |
| C. PROCEEDINGS BELOW .....   | 4    |
| REASONS FOR GRANTING THE WRIT .....  | 6    |
| A. THE ELEVENTH CIRCUIT'S INTERPRETATION OF THE ADA CONFLICTS WITH THE SECOND AND SEVENTH CIRCUITS' INTERPRETATION OF ITS PREDECESSOR, § 504 OF THE REHABILITATION ACT ..... | 6    |
| B. THE DECISION OF THE COURT OF APPEALS VIOLATES IMPORTANT PRINCIPLES OF STATUTORY CONSTRUCTION AND IS INCONSISTENT WITH RECENT DECISIONS OF THIS COURT .....                | 10   |
| C. AS CONSTRUED BY THE COURT OF APPEALS, THE ADA CONFLICTS WITH THIS COURT'S HOLDINGS ON SECTION 5 OF THE FOURTEENTH AMENDMENT .....   | 12   |



## TABLE OF CONTENTS - Continued

|                         | Page |
|-------------------------|------|
| CONCLUSION .....        | 16   |
| INDEX TO APPENDIX ..... | ia   |
| APPENDIX.....           | 1a   |

## TABLE OF AUTHORITIES

|   | Page |
|---|------|
| CASES:  |      |
| <i>Association for Retarded Citizens of North Dakota v. Olson</i> , 713 F.2d 1384 (8th Cir. 1983) ..... | 13   |
| <i>Bragdon v. Abbott</i> , ___ U.S. ___, 118 S.Ct. 2196 (1998) .....                                    | 10   |
| <i>Cable v. Department of Developmental Services</i> , 973 F. Supp. 937 (C.D.Cal. 1997) .....           | 9    |
| <i>Charles Q. v. Houstoun</i> , 1997 U.S. Dist. LEXIS 17305 (M.D. Pa. 1997).....                        | 9    |
| <i>City of Boerne v. Flores</i> , 521 U.S. ___, 117 S.Ct. 2157 (1997) .....                             | 15   |
| <i>City of Cleburne v. Cleburne Living Center</i> , 473 U.S. 432 (1985) .....                           | 14   |
| <i>Clark v. Cohen</i> , 794 F.2d 79 (3d Cir. 1985).....   | 7    |
| <i>Conner v. Branstad</i> , 839 F. Supp. 1346 (S.D. Iowa 1993).....                                     | 7    |
| <i>Gregory v. Ashcroft</i> , 501 U.S. 452 (1991).....   | 12   |
| <i>Griffith v. Ledbetter</i> , 711 F. Supp. 1108 (N.D. Ga. 1989).....                                   | 13   |
| <i>Halderman v. Pennhurst State Sch. and Hosp.</i> , 784 F. Supp. 215 (E.D.Pa. 1992).....               | 7    |
| <i>Helen v. L. DiDario</i> , 46 F.3d 325 (3d Cir. 1985).....  | 7, 8 |
| <i>Heller v. Doe</i> , 509 U.S. 312 (1993).....   | 14   |
| <i>Jackson v. Fort Stanton Hosp. and Training Sch.</i> , 757 F. Supp. 1243 (D.N.M. 1990) .....          | 13   |
| <i>Jackson v. Fort Stanton Hosp. and Training Sch.</i> , 964 F.2d 980 (10th Cir. 1992).....             | 7    |

## TABLE OF AUTHORITIES – Continued

|  | Page      |
|--|-----------|
| <i>Kathleen S. v. Department of Pub. Welfare</i> , 1988 U.S. Dist. LEXIS 11819 (E.D. Pa. 1998) ..... | 9         |
| <i>L.C. v. Olmstead</i> , 138 F.3d 893 (11th Cir. 1998) .....  | 1         |
| <i>Lelsz v. Kavanagh</i> , 807 F.2d 1243 (5th Cir. 1987) .....                                       | 13        |
| <i>Messier v. Southbury Training Sch.</i> , 916 F. Supp. 133 (D. Conn. 1996) .....                   | 9         |
| <i>Miller v. Johnson</i> , 515 U.S. 900 (1995) .....   | 11        |
| <i>P.C. v. McLaughlin</i> , 913 F.2d 1033 (2d Cir. 1990) ...   | 7, 13     |
| <i>Pennhurst State Sch. and Hosp. v. Halderman</i> , 451 U.S. 1 (1981) .....                         | 5, 6      |
| <i>Pennsylvania Dep't of Corrections v. Yeskey</i> , ___ U.S. ___ 118 S.Ct. 1952 (1998) .....        | 12        |
| <i>Pennsylvania Secretary of Pub. Welfare v. Idell S.</i> , 516 U.S. 813 (1995) .....                | 8         |
| <i>Phillips v. Thompson</i> , 715 F.2d 365 (7th Cir. 1983) ..  | 7, 13     |
| <i>Reno v. Bossier Parish Sch. Bd.</i> , ___ U.S. ___ 117 S.Ct. 1491 (1997) .....                    | 11        |
| <i>S.H. v. Edwards</i> , 886 F.2d 292 (11th Cir. 1989) ..  | 7, 13, 14 |
| <i>Schweiker v. Wilson</i> , 450 U.S. 221 (1981) .....   | 14        |
| <i>Society for Good Will to Retarded Children v. Cuomo</i> , 737 F.2d 1239 (2d Cir. 1984) .....      | 13, 14    |
| <i>Youngberg v. Romeo</i> , 457 U.S. 307 (1982) .....  | 13        |
| <i>United States v. Board of Comm'rs of Sheffield, Ala.</i> , 435 U.S. 110 (1978) .....              | 11        |

## TABLE OF AUTHORITIES – Continued

|  | Page   |
|--|--------|
| <i>United States v. Carolene Products Co.</i> , 304 U.S. 144 (1938) .....            | 14     |
| <i>Williams v. Secretary of Executive Office</i> , 609 N.E.2d 447 (Mass. 1993) ..... | 7      |
| <i>Williams v. Wasserman</i> , 937 F. Supp. 524 (D. Md. 1996) .....                  | 9      |
| STATUTES AND REGULATIONS:  |        |
| U.S. Const., amend. XIV .....  | 2      |
| 28 U.S.C. § 1254(1) (1994) .....   | 1      |
| 28 U.S.C. § 2403(a) (1994) .....   | 1      |
| 29 U.S.C. § 794 (1994) .....   | 7      |
| 42 U.S.C. § 12101(a)(3) (1994) .....   | 12     |
| 42 U.S.C. § 12101(a)(7) (1994) .....   | 14     |
| 42 U.S.C. § 12101(b)(4) (1994) .....   | 13     |
| 42 U.S.C. § 12132 (1994) .....   | passim |
| 28 C.F.R. § 35.130(d)(1997) .....  | 5, 8   |
| 28 C.F.R. Pt. 35 (1997) .....  | 7, 11  |
| 43 Fed. Reg. 2132 (1978) .....   | 11     |
| O.C.G.A. Chs. 37-1 through 37-7 (1995) .....   | 4      |
| O.C.G.A. Ch. 37-9 (1995) .....   | 4      |
| O.C.G.A. § 37-1-2 (1995) .....   | 4      |



## TABLE OF AUTHORITIES - Continued

|   | Page |
|---|------|
| O.C.G.A. § 37-1-20 (1995) .....             | 4    |
| O.C.G.A. §§ 37-2-1 to 37-2-6.1 (1995) ..... | 4    |
| O.C.G.A. § 37-3-1(10) (1995) .....          | 4    |
| O.C.G.A. § 37-3-161 (1995) .....            | 4    |
| O.C.G.A. § 37-4-2(10) (1995) .....          | 4    |
| O.C.G.A. § 37-4-121 (1995) .....            | 4    |
| RULES:                                      |      |
| Fed.R.Civ.P. 25(d) .....                    | ii   |
| Supreme Court Rule 29.4(b) .....            | 1    |

## PETITION FOR A WRIT OF CERTIORARI

Petitioners Tommy Olmstead, Ronald C. Hogan, and Earnestine Pittman respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit entered in the above-entitled proceeding on April 8, 1998.

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 OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit is reported as *L.C. v. Olmstead*, 138 F.3d 893 (1998), and is printed as Appendix A, *infra*, 1a. The order on the merits by the United States District Court for the Northern District of Georgia, No. 1:95-CV-1210-MHS, 1997 WL 148674 (Mar. 26, 1997), is printed as Appendix B, *infra*, 31a.

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 JURISDICTION

The court of appeals entered its opinion and judgment on April 8, 1998 (App. A, *infra*, 1a) and entered its denial of Petitioners' Motion For Rehearing and Suggestion of Rehearing En Banc on July 1, 1998 (App. C, *infra*, 43a). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1) (1994). 28 U.S.C. § 2403(a) (1994) may apply and notifications required by Supreme Court Rule 29.4(b) have been made. The court of appeals did not certify the question to the Attorney General pursuant to 28 U.S.C. § 2403(a) (1994).

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## CONSTITUTIONAL AND STATUTORY PROVISIONS

### U.S. Const. Amend. 14:

Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

\* \* \*

Section 5. The Congress shall have the power to enforce, by appropriate legislation, the provisions of this article.

42 U.S.C. § 12132 (1994) (the Americans With Disabilities Act of 1990):

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

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## STATEMENT

### A. Claims and Facts

Respondent L.C. brought this action in May 1995, and Respondent E.W. intervened in January 1996. Both

Respondents were patients at Georgia Regional Hospital at Atlanta, a State residential facility for the care of persons with mental illness, mental retardation, or a substance-abuse condition. For many years before this action, both patients had been hospitalized frequently for treatment.

In the complaints, the patients alleged that they were not receiving minimally adequate treatment in the facility, in violation of their rights under the Fourteenth Amendment. They also asserted that they "could" be treated in the community, that such treatment was "appropriate" for them, and, therefore, that the Americans With Disabilities Act (the "ADA") required the provision of such treatment.

The patients sought a declaratory judgment as well as an injunction requiring the officials to provide them with publicly financed community residential placements and professional services. The State officials answered both complaints by denying that the patients had failed to receive minimally adequate treatment at the facility and denying that they required community-based services.

The parties developed an extensive record below. It establishes that after their admission to and treatment at Georgia Regional Hospital at Atlanta, the patients both stabilized to the point that they could have been discharged to a highly structured community placement. However, they continued to receive treatment at the facility and they were not initially discharged; the State asserted that this was due to a lack of funding for the



community placements. During the course of the litigation, both patients were provided with community placements, as funding became available.

### B. Georgia's Provisions for Care

This case arose in the context of Georgia's elaborate legal and fiscal framework for delivering mental health, mental retardation, and substance abuse services. O.C.G.A. Chs. 37-1 through 37-7, 37-9 (1995). Georgia law establishes a coordinated system of state, regional, and community agencies for implementing and managing this delivery. O.C.G.A. §§ 37-1-20, 37-2-1 to 37-2-6.1 (1995).

The statutes detail the broad spectrum of programs and placements in which services may be delivered. That spectrum includes State hospitals and other institutional facilities, various community placements, as well as outpatient treatment. *See, e.g.*, O.C.G.A. § 37-1-2 (1995) (providing for a "comprehensive range of quality services").

Georgia law also sets substantive standards for both voluntary and involuntary treatment. For both types of treatment, State law establishes a preference for treatment in the least restrictive setting, O.C.G.A. §§ 37-3-161, 37-4-121 (1995), but only "within the limits of state funds specifically appropriated therefor." O.C.G.A. §§ 37-3-1(10), 37-4-2(10) (1995).

### C. Proceedings Below

After the close of discovery, the parties filed cross-motions for summary judgment on the whole case. The patients' primary argument was that the sense of the

ADA is embodied in a regulation calling for provision of public services in the "most integrated setting," and that mental health and mental retardation facilities are *per se* a "segregated" setting. 28 C.F.R. § 35.130(d) (1997) (App. D, *infra*, 45a). The State officials argued that, at the threshold, the ADA requires a showing of causation (i.e., a showing that the State's failure to provide community services occurred due to the patients' disabilities), and that this showing had not been made. They asserted also that the "integration" regulation, according to its history and intent, does not compel community treatment.

The district court granted the patients' motion on the ADA claim and ordered the State to place and maintain the patients in an "appropriate" residential community setting, based on its conclusion that "under the ADA, unnecessary institutional segregation of the disabled constitutes discrimination *per se*, which cannot be justified by a lack of funding."<sup>1</sup>

On appeal, the court of appeals affirmed the district court's judgment, but then it also remanded the case for factual findings on the State's funding defense. App. A, *infra*, 1a, 4a. The court of appeals at the outset concluded that "[b]y definition where, as here, the State confines an individual with a disability in an institutionalized setting when a community placement is appropriate, the State has violated the core principle underlying the ADA's integration mandate." App. A, *infra*, 8a.

<sup>1</sup> App. B, *infra*, 31a. The district court found that the patients' claims were not moot generally, as they were capable of repetition but would evade review. *Id.* at 35a.

The court then declared that under the ADA lack of funds was not a defense except "in the most limited of circumstances." *Id.* at 20a. It held that "where, as here, the evidence is clear that all the experts agree that, at a given time, the patient could be treated in a more integrated setting, the ADA mandates that it do so at that time unless placing that individual would constitute a fundamental alteration in the state's provision of services." *Id.* at 24a. The court of appeals underscored the magnitude of the officials' burden on remand by stating that "[u]nless the State can prove that requiring it to make these additional expenditures [for the community placements] would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides, the ADA requires the State to make these additional expenditures." *Id.* at 29a.

## REASONS FOR GRANTING THE WRIT

### A. The Eleventh Circuit's Interpretation of the ADA Conflicts With the Second and Seventh Circuits' Interpretation of Its Predecessor, § 504 of the Rehabilitation Act.

The issue of whether a mental patient is entitled to State-provided treatment in the least restrictive environment, instead of in an institution, has been vigorously litigated on numerous grounds for over twenty years. See, e.g., *Pennhurst State Sch. and Hosp. v. Halderman*, 451 U.S. 1, 24 (1981) (treatment in the least restrictive environment would create an "enormous financial burden" and a

"massive obligation" on States). This Court has never addressed this issue under the ADA.

Until recently, almost all of the lower courts had found that neither § 504 of the Rehabilitation Act of 1973<sup>2</sup> nor the ADA required the States to provide mental treatment in a community placement simply because it was possible, appropriate, or even better than institutional treatment. By 1993, three circuit courts, numerous district courts, and one state supreme court had expressly found that the plaintiff must show discrimination, based on the plaintiff's disability relative to other disabled persons receiving community services, in order to state a claim.<sup>3</sup> No court had found that institutional treatment of a mentally disabled individual constituted discrimination

<sup>2</sup> 29 U.S.C. § 794 (1994). Congress intended that the public services section of the ADA adhere closely to § 504. See Preamble, 28 C.F.R. Pt. 35, App. A, at 448-9 (1997).

<sup>3</sup> Circuit courts: *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. 1990); *Clark v. Cohen*, 794 F.2d 79 (3rd Cir. 1985), *cert. denied*, 479 U.S. 962 (1986) (later limited in *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir.), *cert. denied*, 516 U.S. 813 (1995)); *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983). District courts: *Conner v. Branstad*, 839 F. Supp. 1346 (S.D. Iowa 1993); *Jackson v. Fort Stanton Hosp. and Training Sch.*, 757 F. Supp. 1243 (D.N.M. 1990), *rev'd in part on other grounds*, 964 F.2d 980 (10th Cir. 1992); *S.H. v. Edwards*, No. C81-877A (N.D. Ga. 1987) (reprinted at 860 F.2d 1046-1053), *aff'd*, 860 F.2d 1045 (11th Cir. 1988), *reh'g en banc denied*, 866 F.2d 1420 (11th Cir. 1989), *cert. denied*, 491 U.S. 905 (1989), *reh'g en banc granted and panel opinion vacated*, 880 F.2d 1203 (11th Cir. 1989), *aff'd apparently on other grounds*, 886 F.2d 292 (11th Cir. 1989) (distinguished by panel in present case, App. A, *infra*, 19a). State courts: *Williams v. Secretary of Executive Office*, 609 N.E.2d 447 (Mass. 1993) (distinguished in *Helen L.*, *supra*). But see *Halderman v. Pennhurst State Sch. & Hosp.*, 784 F. Supp. 215, 224 (E.D.Pa. 1992), *aff'd*, 977 F.2d 568 (3d Cir. 1992).



under § 504 or the ADA, simply because treatment in the community might also be appropriate.

In 1995, however, the Third Circuit held that treatment of an individual in a nursing home constituted discrimination *per se* under the ADA, if the state could also provide treatment through its home-based attendant care program. *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995), *cert. denied sub nom. Pennsylvania Secretary of Pub. Welfare v. Idell S.*, 516 U.S. 813 (1995). The Court relied primarily on its interpretation of the so-called "integration regulation" for its finding. 28 C.F.R. § 35.130(d) (1997) (App. D, *infra*, 45a).

The Eleventh Circuit's decision in this case closely followed the Third Circuit's rationale. The Eleventh Circuit ignored the opposing authority cited above, because those cases did not consider the integration regulation. App. A, *infra*, 19a. However, that regulation had been issued in 1978, and prior to *Helen L.* no court had ever interpreted it to find that the ADA or § 504 placed an obligation on the States to provide certain kinds of treatment to the disabled.

In the short time since *Helen L.* was decided, it has been widely cited for its interpretation of the ADA.<sup>4</sup> At least five district courts have cited *Helen L.* for its specific holding that institutional treatment constitutes discrimination *per se* under the integration regulation. Of those five district courts, two have found for plaintiffs based on the *per se* discrimination interpretation without a separate

<sup>4</sup> Shepard's citations showed "170 Citing References" to *Helen L.*, *supra*, on September 15, 1998.

finding of discrimination,<sup>5</sup> two have relied instead on a showing of discrimination among disability groups,<sup>6</sup> and one has relied on both interpretations.<sup>7</sup> In light of the split in the circuit courts on this issue, and the current activity in the district courts, the federal courts most certainly will continue to be faced with the question of the proper interpretation of the ADA. This Court should accept certiorari of this important decision now, rather than to delay and allow this confusion, with its disruption of state planning and budgeting, to continue.

Clearly, the seventeen disability organizations that signed the two amicus briefs below on behalf of the plaintiffs believe that the court of appeals' decision is of far-reaching importance.<sup>8</sup> Additionally, it is expected that

<sup>5</sup> *Kathleen S. v. Department of Pub. Welfare*, 1998 U.S. Dist. LEXIS 11819 (E.D.Pa. 1998) (unreported); *Charles Q. v. Houstoun*, 1997 U.S. Dist. LEXIS 17305 (M.D.Pa. 1997) (unreported).

<sup>6</sup> *Cable v. Department of Developmental Services*, 973 F. Supp. 937 (C.D.Cal. 1997); *Messier v. Southbury Training Sch.*, 916 F. Supp. 133 (D.Conn. 1996).

<sup>7</sup> *Williams v. Wasserman*, 937 F. Supp. 524 (D.Md. 1996).

<sup>8</sup> American Ass'n. on Mental Retardation, Network of Community Options and Resources, American Disabled for Attendant Programs Today, The Arc of the United States, Brain Injury Ass'n., Joseph P. Kennedy Foundation, Mental Health Ass'n. of Ga., Mental Health Ass'n. of Metro Atlanta, National Alliance for the Mentally Ill, National Ass'n. of Protection and Advocacy, National Council on Independent Living, National Mental Health Ass'n., NE Ga. Coalition of Disability Advocates, Statewide Independent Living Council of Ga., Advocacy Center for Persons With Disabilities, Ala. Disability Advocacy Program, and Ga. Advocacy Office.

the Department of Justice will seek national enforcement of the Third and Eleventh Circuit's interpretations of the ADA. Thus, the "*per se* discrimination" interpretation will have national impact.

This Court should not wait until after the case has been remanded. The State should not be required to prove that providing community treatment for plaintiffs would require a fundamental alteration to the State's programs, because plaintiffs have failed at the outset to establish that they suffered discrimination based on their disability. The fundamental issue of whether Congress intended for institutional treatment to constitute discrimination *per se* can and should be decided first.

**B. THE DECISION OF THE COURT OF APPEALS VIOLATES IMPORTANT PRINCIPLES OF STATUTORY CONSTRUCTION AND IS INCONSISTENT WITH RECENT DECISIONS OF THIS COURT.**

This Court has recently illustrated the proper approach to interpreting the ADA in *Bragdon v. Abbott*, \_\_\_ U.S. \_\_\_, 118 S.Ct. 2196, 141 L.Ed.2d 540 (1998). "When administrative and judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well." \_\_\_ U.S. at \_\_\_, 118 S.Ct. at 2208, 141 L.Ed.2d at 562. As discussed above, judicial interpretations of § 504 found that it required a showing of discrimination in the provision of benefits due to a disability, and thus institutional treatment was not found to constitute discrimination *per*

*se*. Further, none of these cases ever suggested that the integration regulation might compel community treatment.

No formal administrative interpretation ever stated that § 504 or the integration regulation required community placement for treatment of the disabled. For example, "integration" was considered in the context of providing "equal opportunity" for disabled persons to participate in federally assisted programs for the non-disabled, not in terms of the provision of community treatment for the disabled. 43 Fed. Reg. 2132, 2134 (1978) (statement of Joseph Califano) (App. E, *infra*, 46a). Additionally, as late as 1991, the Attorney General interpreted the terms "segregation" and "integration" in the context of allowing disabled persons access to programs provided for the non-disabled, and not in the context of institutional treatment for the disabled or even discrimination among classes of the disabled. 28 C.F.R. Pt. 35, App. A, 465, 474-479 (1997) (preamble originally published in 1991) (App. F, *infra*, 47a).

Thus, the Justice Department's current litigation position conflicts with its own prior administrative interpretations, as well as with prior judicial interpretations of § 504. Since Congress substantially re-enacted § 504 in the ADA, with a specific reference to the existing regulations, it approved the regulations as they had already been interpreted. The Justice Department's current litigation position thus conflicts with congressionally-approved interpretation, and it was error for the court of appeals to defer to the Department's construction. *Reno v. Bossier Parish Sch. Bd.*, \_\_\_ U.S. \_\_\_, 117 S.Ct. 1491, 137 L.Ed.2d 730 (1997); *Miller v. Johnson*, 515 U.S. 900 (1995); *United*



*States v. Board of Comm'rs of Sheffield, Ala.*, 435 U.S. 110 (1978). Further, the court of appeals' deference to the Department's interpretation "in this and other similar litigation . . ." (App. A, *infra*, 7a-8a) is improper, because an agency's litigation position "is entitled to little if any deference." *Gregory v. Ashcroft*, 501 U.S. 452, 485, n.3 (1991) (White, J., concurring).

Additionally, the interpretation now urged by the Department of Justice, and followed by the Third and Eleventh Circuits, relies on the Act's use of the word "institutionalization" to claim that Congress intended that institutionalization applied only to the disabled and that it constituted discrimination. 42 U.S.C. § 12101(a)(3) (1994); App. A, *infra*, 17a-18a. Yet a reading of that section *in context* shows that "institutionalization" is discrimination-neutral, just as "employment," "housing," "education," and "recreation" are discrimination-neutral. *Id.* This Court recently has made this clear, by assuming that "institutionalization" can include penal institutions. *Pennsylvania Dep't of Corrections v. Yeskey*, \_\_\_ U.S. \_\_\_, 118 S.Ct. 1952, 141 L.Ed.2d 215 (1998).

**C. AS CONSTRUED BY THE COURT OF APPEALS, THE ADA CONFLICTS WITH THIS COURT'S HOLDINGS ON SECTION 5 OF THE FOURTEENTH AMENDMENT.**

If Title II of the ADA means what the court of appeals says that it does, then a substantial constitutional issue emerges: whether the ADA, which expressly relies on the enforcement power granted to Congress in Section 5 of

the Fourteenth Amendment,<sup>9</sup> 42 U.S.C. § 12101(b)(4) (1994), exceeds that power. The foundations for this issue consist of two settled principles of Fourteenth Amendment jurisprudence.

First, there is no *per se* right under the substantive component of the Due Process Clause to a community placement or a "least restrictive environment" for a mentally ill or mentally retarded person. Rather, such a placement or environment is constitutionally required only when that is the only setting in which minimally adequate care can be provided, or in other words only when the State officials' decision to place or retain a patient in a residential facility so substantially departs "from accepted professional judgment, practice, or standards as to demonstrate that the person actually did not base the decision on such judgment." *Society for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1248 (2d Cir. 1984) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982)).<sup>10</sup> "Minimally adequate care" is the constitutional requirement, not "appropriate" care, "better" care, or care

<sup>9</sup> Section 5 provides that "[t]he Congress shall have power to enforce, by appropriate legislation, the provisions of this article."

<sup>10</sup> Accord: *Jackson v. Fort Stanton Hosp. & Training Sch.*, 964 F.2d 980, 992 (10th Cir. 1992); *P.C. v. McLaughlin*, 913 F.2d 1033, 1042 (2d Cir. 1990); *S.H. v. Edwards*, 886 F.2d 292 (11th Cir. 1989) (*en banc*), *aff'g*, No. C81-877A (N.D. Ga. 1987) (reprinted at 860 F.2d 1046-1053); *Lelsz v. Kavanagh*, 807 F.2d 1243, 1249 (5th Cir. 1987); *Phillips v. Thompson*, 715 F.2d 365, 368 (7th Cir. 1983); *Association for Retarded Citizens of North Dakota v. Olson*, 713 F.2d 1384, 1392 (8th Cir. 1983), *aff'g on other grounds*, 561 F. Supp. 473, 486 (D.N.D. 1982); *Griffith v. Ledbetter*, 711 F. Supp. 1108, 1110 (N.D. Ga. 1989).

that will make patients "safer, happier, or more productive." *S.H.*, *supra*, No. C81-877A (reprinted, 860 F.2d at 1049); *Cuomo*, *supra*, at 1248. This constitutional law clearly differs from the ADA, whose "core principle," according to the court of appeals, is violated "[b]y definition where, as here, the State confines an individual with a disability in an institutional setting when a community placement is appropriate. . . ." App. A, *infra*, 8a.

Second, mental disability is not a suspect or "quasi-suspect classification calling for a more exacting standard of judicial review than is normally accorded economic and social legislation." *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 442 (1985) (mental retardation); see *Heller v. Doe*, 509 U.S. 312, 318-319 (1993); *Schweiker v. Wilson*, 450 U.S. 221, 330-31 (1981). This principle, too, differs from the ADA, which expressly asserts that

individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society. . . .

42 U.S.C. § 12101(a)(7) (1994). This language, of course, echoes footnote 4 of *United States v. Carolene Products Co.*, 304 U.S. 144, 152-153 (1938), where the Court postpones considering "whether prejudice against discrete and insular minorities . . . may call for a correspondingly more searching judicial inquiry." The statutory language, then, is a finding that disabled persons such as the patients here are entitled to a higher degree of protection than this Court has provided them under the Fourteenth Amendment.

With this foundation, the constitutional issue becomes clear. As the Court held in *City of Boerne v. Flores*, 521 U.S. \_\_\_, \_\_\_, 117 S.Ct. 2157, 2164, 138 L.Ed.2d 624, 638 (1997), a religious-freedom case:

The design of the Amendment and the text of § 5 are inconsistent with the suggestion that Congress has the power to decree the substance of the Fourteenth Amendment's restrictions on the States. Legislation which alters the meaning of the Free Exercise Clause cannot be said to be enforcing the Clause. Congress does not enforce a constitutional right by changing what the right is.

The Court noted that the legislation in question exceeded Section 5 because its "sweeping coverage ensures its intrusion at every level of government" and because it "was designed to control cases and controversies." 521 U.S. at \_\_\_, \_\_\_, 117 S.Ct. at 2170, 2172, 138 L.Ed.2d at 646, 649.

The present case concerns alleged discrimination against a classification of persons for which the Fourteenth Amendment provides no extraordinary protection. The text of the ADA attempts to provide such protection anyway. It also, in the view of the court of appeals, creates an essentially *per se* right to community placement, contrary to the Fourteenth Amendment. Finally, the ADA imposes the duty to implement this right on every State and local government, despite the long history of State and local control of public services for persons with mental disabilities. The court of appeals' opinion in this case thus profoundly disturbs the delicate balance



between the national government and the State governments, and in doing so seriously conflicts with this Court's careful calibration of that balance. Plenary review is thus required.

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### CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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### INDEX TO APPENDIX

|            |   |     |
|------------|---|-----|
| Appendix A | Opinion of the Court of Appeals.....  | 1a  |
| Appendix B | Decision of the United States District Court For the Northern District of Georgia ..... | 31a |
| Appendix C | Denial of Motion for Rehearing and Suggestion of Rehearing En Banc .....                | 43a |
| Appendix D | 28 C.F.R. § 35.130(d) (1997).....   | 45a |
| Appendix E | 43 Fed. Reg. 2132, 2134 (1978).....   | 46a |
| Appendix F | 28 C.F.R. Pt. 35, App. A, 465, 474-479 (1997).....                                      | 47a |

**APPENDIX A**

**UNITED STATES COURT OF APPEALS  
FOR THE ELEVENTH CIRCUIT**

L.C., by Jonathan ZIMRING as guardian ad litem and next friend; E.W., Plaintiffs-Appellees, v. Tommy OLMSTEAD, Commissioner of the Department of Human Resources; Richard Fields, Superintendent of Georgia Regional Hospital at Atlanta; Earnestine Pittman, Executive Director of the Fulton County Regional Board, all in their official capacities, Defendants-Appellants.

No. 97-8538.

April 8, 1998, Decided

SUBSEQUENT HISTORY: Rehearing En Banc Denied July 1, 1998, Reported at: 1998 U.S. App. Lexis 20760.

PRIOR HISTORY: Appeal from the United States District Court for the Northern District of Georgia. (No. 1:95-CV-1210-MHS). Marvin H. Shoob, District Judge.

DISPOSITION: Judgment of the district court AFFIRMED and case REMANDED for further proceedings consistent with this opinion.

COUNSEL: For APPELLANT(S): Office of the State Attorney General, William F. Amideo, Atlanta, GA. Patricia Downing, Atlanta, GA. Jefferson James Davis, Decatur, GA.

For APPELLEE(S): Susan C. Jamieson, Atlanta Legal Aid Society, Decatur, GA. Steven D. Caley, Atlanta Legal Aid Society, Atlanta, GA.



JUDGES: Before TJOFLET and BARKETT, Circuit Judges, and PROBST\*, Senior District Judge.

OPINION: BARKETT, Circuit Judge:

Tommy Olmstead, Richard Fields, and Earnestine Pittman, (collectively "the State"), defendants in the district court, appeal an adverse summary judgment granting declaratory and injunctive relief to plaintiffs L.C. and E.W.,<sup>1</sup> two patients then-housed in a state psychiatric hospital.<sup>2</sup> In May 1995, L.C. filed this action challenging

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\* Honorable Robert B. Propst, Senior U.S. District Judge for the Northern District of Alabama, sitting by designation.

<sup>1</sup> As the district court did, we use the pseudonyms L.C. and E.W. in order to protect plaintiffs' identities.

<sup>2</sup> Both L.C. and E.W. are currently being treated in community-based programs. L.C. was placed in a community-based program in February 1996, while this action was pending in the district court; E.W. was placed in a similar program after the district court entered its judgment. Nonetheless, this case is not moot. Mootness has been defined as "the doctrine of standing set in a time frame: The requisite personal interest that must exist at the commencement of the litigation (standing) must continue through its existence (mootness)." *United States Parole Comm'n v. Geraghty*, 445 U.S. 388, 397, 100 S. Ct. 1202, 1209, 63 L. Ed. 2d 479 (1980) (quoting Monaghan, *Constitutional Adjudication: The Who and When*, 82 Yale L.J. 1363, 1384 (1973)). As the district court concluded, L.C.'s suit falls under the exception for cases that are "capable of repetition, yet evading review." L.C. has been confined eighteen different times at the same psychiatric hospital, GRH-A and her current placement has been unstable at times due to the State's failure to provide adequate funding. Therefore, it is likely that L.C. may be returned to GRH-A. Further, because of the complexity of the issues involved and instability of her placements, it is likely that any future claim for relief will evade our review. See *Honig v. Doe*, 484 U.S. 305, 318-23, 108 S. Ct. 592, 601-04, 98 L. Ed. 2d 686

her continued confinement at the Georgia Regional Hospital in Atlanta ("GRH-A"), a psychiatric hospital where persons with mental disabilities are cared for in a segregated environment. The State's failure to provide her with care in the most integrated setting appropriate to her needs, she argued, violated Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12131-12134 (1995), the Attorney General's Title II regulations, 28 C.F.R. § 35.130 (1997), and the Due Process Clause of the Fourteenth Amendment. In January 1996, E.W., a patient also confined at GRH-A, intervened in this action, raising identical claims.

In granting summary judgment in favor of L.C. and E.W., the district court declared that the State's failure to place them in an appropriate community-based treatment program, instead confining them at the state hospital, violates the anti-discrimination provision of Title II of the ADA, 42 U.S.C. § 12132, and its accompanying regulations. The district court enjoined the State from violating plaintiffs' rights under the ADA, determined that the denial of community placements could not be justified by the State's purported lack of funds, and ordered the State to release E.W. to an appropriate community-based treatment program and to provide L.C. with all appropriate

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(1988); *Lynch v. Baxley*, 744 F.2d 1452, 1456-57 (11th Cir. 1984). As to E.W., because the State only placed her in a community-based treatment program under court order, it is likely that, absent the court order, the State might revert to its prior practices. See *Vitek v. Jones*, 445 U.S. 480, 486-87, 100 S. Ct. 1254, 1260-61, 63 L. Ed. 2d 552 (1980). Further, like L.C., E.W. has been subject to multiple and unstable placements at GRH-A, making her claim one that is capable of repetition, yet evading review.

services necessary to maintain her current placement in a community-based treatment program.

We affirm the district court's judgment that the State discriminated against L.C. and E.W. by confining them in a segregated institution rather than in an integrated community-based program. However, we remand this case to the district court for further findings related to the State's defense that the relief sought by plaintiffs would "fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7).<sup>3</sup>

#### DISCUSSION

This case presents the question, one of first impression in this circuit, whether § 12132 of the ADA and the Department of Justice's integration regulation, 28 C.F.R. § 35.130(d), prohibit a state from confining a disabled individual in a state-run institution where that individual could be appropriately treated in a more integrated community setting. The State's principal argument is that the district court's application of § 12132 and its accompanying regulations is contrary to the ADA's requirement that a plaintiff prove that he or she faced discrimination "by reason of such disability." § 12132. The State contends that L.C. and E.W. have not shown that they were denied community placements available to non-disabled individuals because of disability. In other words, the State argues

<sup>3</sup> The State also claims that it was entitled to summary judgment on plaintiffs' constitutional claims. Because the district court did not consider these claims, we decline to do so as well. *Citro Florida, Inc. v. Citrovale, S.A.*, 760 F.2d 1231, 1232 (11th Cir. 1985).

that the ADA requires a comparison of the treatment of individuals with disabilities against that of healthy non-disabled persons. However, as the State must concede, the confinement of L.C. and E.W. at GRH-A is attributable to their disabilities, thereby proving the very element the State argues is missing. Reduced to its essence, the State's argument is that Title II of the ADA affords no protection to individuals with disabilities who receive public services designed only for individuals with disabilities.

The State has not pointed to any legal authority that supports such a reading of Title II of the ADA and its integration regulation, § 35.130(d), and we can find none. To the contrary, we find overwhelming authority in the plain language of Title II of the ADA, its legislative history, the Attorney General's Title II regulations, and the Justice Department's consistent interpretation of those regulations, to support L.C. and E.W.'s position.

We analyze the applicability of the ADA and its regulations first by discussing the plain language of Title II of the ADA and § 35.130(d), the integration regulation, and the Attorney General's interpretation of that language. We then consider, in light of congressional intent, the State's argument that, notwithstanding the plain language of § 35.130(d) and the Attorney General's interpretation of that regulation, the ADA does not apply in these circumstances. We next address the State's secondary argument that certain disputed issues of fact preclude summary judgment. Finally, we consider the State's argument that funding limitations preclude it from complying with the ADA.



## I.

Title II of the ADA prohibits discrimination against individuals with disabilities in the provision of public services by state and local governments. Section 12132 provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." § 12132.

Under the statutory scheme of Title II, Congress entrusted the Attorney General with the authority to define the scope of the prohibitions set forth in § 12132. In § 12134 of the ADA, Congress directed the Attorney General to promulgate regulations further defining Title II's anti-discrimination mandate. See 42 U.S.C. § 12134(a); H.R. Rep. 101-485, pt. 3 at 52 (1990) ("Title II does not list all the forms of discrimination that the title is intended to prohibit. Thus, the purpose of this section is to direct the Attorney General to issue regulations setting forth the forms of discrimination prohibited."). Congress additionally mandated that the Attorney General's regulations, except with regard to program accessibility, existing facilities, and communications issues, be "consistent with this chapter and with the coordination regulations under part 41 of title 28, Code of Federal Regulations . . . applicable to recipients of Federal financial assistance under [section 504 of the Rehabilitation Act]." 42 U.S.C. § 12134(b).<sup>4</sup>

<sup>4</sup> Section 504 of the Rehabilitation Act, in turn, provides that "no otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability,

In response to this congressional mandate, the Attorney General issued regulations defining the forms of discrimination prohibited by Title II of the ADA. Because Congress left to the Attorney General the task of giving meaning to § 12132's broad prohibition on discrimination in public services, the Attorney General's regulations must be "given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 844, 104 S. Ct. 2778, 2782, 81 L. Ed. 2d 694 (1984); *Bledsoe v. Palm Beach County Soil & Water Conserv. Dist.*, 133 F.3d 816, 822-23 (11th Cir. 1998); *Harris v. H & W Contracting Co.*, 102 F.3d 516, 521 (11th Cir. 1996); *Helen L. v. DiDario*, 46 F.3d 325, 331-32 (3d Cir. 1995).

Under the Attorney General's Title II implementing regulations, "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). There can be little question that the plain language of § 35.130(d) prohibits a state from providing services to individuals with disabilities in an unnecessarily segregated setting. See 28 C.F.R. Pt. 35, App. A at 478 (interpreting § 35.130(d) to require placement "in a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible"). In participating in this and other

be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service." 29 U.S.C. § 794(a) (1995).

similar litigation, the Attorney General has consistently adopted this interpretation of § 35.130(d), and, as such, it is entitled to substantial deference. *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512, 114 S. Ct. 2381, 2386-87, 129 L. Ed. 2d 405 (1994); *University Health Servs., Inc. v. Health & Human Servs.*, 120 F.3d 1145, 1150 (11th Cir. 1997).

By definition, where, as here, the State confines an individual with a disability in an institutionalized setting when a community placement is appropriate, the State has violated the core principle underlying the ADA's integration mandate. Placement in the community provides an integrated treatment setting, allowing disabled individuals to interact with non-disabled persons – an opportunity permitted only in limited circumstances within the walls of segregated state institutions such as GRH-A. The State does not seriously contend otherwise. Nor does it even attempt to show that the Attorney General's interpretation is "plainly erroneous or inconsistent with the regulation" as it must to overturn her construction of § 35.130(d). *Thomas Jefferson*, 512 U.S. at 512, 114 S. Ct. at 2386 (quoting *Udall v. Tallman*, 380 U.S. 1, 16-17, 85 S. Ct. 792, 801, 13 L. Ed. 2d 616 (1965)).

Because the express terms of § 35.130(d), supported by the Attorney General's consistent interpretation, plainly prohibit a state from treating individuals with disabilities in a segregated environment where a more integrated setting would be appropriate, we can only reverse the district court's finding that the State's actions in this case constituted discrimination within the meaning of the ADA by holding § 35.130(d) invalid. Thus, we turn to the State's argument that § 12132's requirement

that a disabled plaintiff prove that he or she faced discrimination "by reason of such disability" precludes application of the ADA in the circumstances presented here.

## II.

After review, we are unable to credit the State's argument that the ADA does not bar a state from providing public services for individuals with disabilities in a segregated manner because every indication of congressional intent confirms that the ADA applies to the circumstances presented here. As noted earlier, in passing the ADA, Congress mandated that the Attorney General promulgate regulations consistent with the coordination regulations issued pursuant to § 504 of the Rehabilitation Act. Congress' decision to incorporate the § 504 coordination regulations is particularly significant here. The Attorney General's § 504 coordination regulations mandate that recipients of federal financial assistance "administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 C.F.R. § 41.51(d) (1997) (emphasis added). By requiring the Attorney General to follow the § 504 coordination regulations – including the explicit integration requirement – Congress expressly mandated that individuals with disabilities receive public services in the most integrated setting appropriate to their needs. Conforming to this mandate, § 35.130(d) tracks this very language.<sup>5</sup>

<sup>5</sup> In line with § 12134(b)'s mandate to promulgate regulations consistent with other parts of the ADA, the Attorney General's Title II regulations are also consistent with



It is well-settled that where "a Congress that re-enacts a statute voices its approval of an administrative . . . interpretation thereof, Congress is treated as having adopted that interpretation, and this Court is bound thereby." *United States v. Board of Comm'rs of Sheffield, Ala.*, 435 U.S. 110, 134, 98 S. Ct. 965, 980, 55 L. Ed. 2d 148 (1978); *Don E. Williams Co. v. Commissioner*, 429 U.S. 569, 576-77, 97 S. Ct. 850, 855-56, 51 L. Ed. 2d 48 (1977). Although Title II of the ADA did not re-enact § 504 of the Rehabilitation Act, the plain language of the ADA makes clear that Congress ratified the Attorney General's § 504 coordination regulations and sought to ensure that the Attorney General's Title II regulations tracked the § 504 coordination regulations. Under these circumstances, both sets of regulations, including the integration provisions, have the force of law. *Helen L.*, 46 F.3d at 332; *Messier v. Southbury Training Sch.*, 916 F.Supp. 133, 141 (D.Conn. 1996).

Congress' determination that public services be provided in the most integrated setting appropriate to the needs of individuals with disabilities is likewise reflected in the ADA's congressional findings and the Act's legislative history. The Act's findings and legislative history make clear that Congress sought to eliminate the segregation of individuals with disabilities in passing the ADA.

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the provisions of Title III. See 42 U.S.C. § 12182(b)(1)(B) (1995) ("Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.").

In enacting the ADA, Congress determined that discrimination against individuals with disabilities persists in a wide variety of areas of social life, including "institutionalization," 42 U.S.C. § 12101(a)(3) (1995), and that "individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion . . . [and] segregation. . . ." 42 U.S.C. § 12101(a)(5); see also 42 U.S.C. § 12101(a)(2) ("Historically, society has tended to isolate and segregate individuals with disabilities, and . . . such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.").

Indeed, the legislative history makes clear that Congress considered the provision of segregated services to individuals with disabilities a form of discrimination prohibited by the ADA. See S.Rep. No. 101-116 at 20 (1989) (noting "compelling need to provide a clear and comprehensive national mandate . . . for the integration of persons with disabilities into the economic and social mainstream of American life"); H.R.Rep. No. 101-485, pt. 2 at 29 (1990), reprinted in 1990 U.S.C.C.A.N. 267, 310 (listing "segregation" as a form of "discrimination against people with disabilities"); H.R. Rep. No. 101-485, pt. 3 at 26 (1990), reprinted in 1990 U.S.C.C.A.N. at 449 ("The ADA is a comprehensive piece of civil rights legislation which promises a new future: a future of inclusion and integration, and the end of exclusion and segregation."). Noting that "the purpose of Title II is to continue to break down barriers to the integrated participation of people with disabilities in all aspects of community life," *id.* at 49-50, reprinted in 1990 U.S.C.C.A.N. at 472-73, the

House Committee on the Judiciary explained that "integrated services are essential to accomplishing the purposes of Title II. . . . Separate-but-equal services do not accomplish this central goal and should be rejected." *Id.* at 50, reprinted in 1990 U.S.C.C.A.N. at 473. Indeed, drawing an analogy to the segregation of African-Americans, the House Report noted that "segregation for persons with disabilities 'may affect their hearts and minds in a way unlikely ever to be undone.'" *Id.* at 26, reprinted in 1990 U.S.C.C.A.N. at 448-49 (quoting *Brown v. Board of Educ.*, 347 U.S. 483, 494, 74 S. Ct. 686, 691-92, 98 L. Ed. 873 (1954)). Certainly, the denial of community placements to individuals with disabilities such as L.C. and E.W. is precisely the kind of segregation that Congress sought to eliminate.

Accordingly, because § 35.130(d) finds direct support in the plain language of the ADA, its congressional findings, and the Act's legislative history, we must apply it here. See *Bledsoe*, 133 F.3d at 823 (deferring to ADA's Title II regulations); *Harris*, 102 F.3d at 521 ("We cannot disregard the interpretive guidance contained in the appendix prepared by the federal agency charged with enforcing the ADA, when that guidance is based on a permissible construction of the statute and is supported by the statute's legislative history.").

We see nothing in the ADA's requirement that discrimination be "by reason of such disability" that warrants a different result. The fact that L.C. and E.W. seek community-based treatment services that only disabled persons need does not foreclose their claim that they were unnecessarily segregated. The ADA does not only mandate that individuals with disabilities be treated the

same as persons without such disabilities. Underlying the ADA's prohibitions is the notion that individuals with disabilities must be accorded reasonable accommodations not offered to other persons in order to ensure that individuals with disabilities enjoy "equality of opportunity, full participation, independent living, and economic self-sufficiency. . . ." § 12101(a)(8); see *Willis v. Conopco, Inc.*, 108 F.3d 282, 285 (11th Cir. 1997) (describing "the basic goal of the ADA" as "ensuring that those with disabilities can fully participate in all aspects of society"). This principle, explicit in the text of the Act's employment provisions in Title I, see 42 U.S.C. § 12112(b)(5)(A) (1995), and the Title II regulations, runs throughout the ADA. See *Bledsoe*, 133 F.3d at 820-25 (applying Title I reasonable accommodation mandate to Title II).

For example, under Title I of the ADA, employers may not terminate individuals with known disabilities who can perform the essential functions of the job with a reasonable accommodation even though the employer need not offer similar accommodations to nondisabled employees. See *Harris*, 102 F.3d at 519 (noting that the ADA "operates to create an affirmative duty for employers to reasonably accommodate individuals with disabilities"); see also *Sieberns v. Wal-Mart Stores, Inc.*, 125 F.3d 1019, 1021-22 (7th Cir. 1997) (noting that the "ADA encompasses two distinct types of discrimination": "treating a 'qualified individual with a disability' differently because of the disability, i.e. disparate treatment" and "failing to provide a reasonable accommodation"). The employer's failure to live up to its duty to provide a reasonable accommodation is unlawful disability-based discrimination. See *Stewart v. Happy Herman's Cheshire*



*Bridge, Inc.*, 117 F.3d 1278, 1285 (11th Cir. 1997) (“[A] qualified individual with a disability may be unlawfully discriminated against because of the individual’s disability when the individual’s employer does not reasonably accommodate the disability – unless such an accommodation would impose an undue hardship on the employer.”); see also *Duckett v. Dunlop Tire Corp.*, 120 F.3d 1222, 1224 (11th Cir. 1997) (noting that the ADA defines discrimination to include failure to make reasonable accommodations to a qualified individual with a disability).

Here, the Attorney General, guided by Congress’ explicit approval of the § 504 coordination regulations, imposed a duty analogous to the reasonable accommodation mandate in the employment setting. This duty requires states to place individuals with disabilities in the most integrated setting appropriate to their needs when receiving services for their disabilities in order to ensure that they become integrated into communities, not isolated from the rest of our society in state-run institutions. Under § 35.130(d), the failure to provide the most integrated services appropriate to the needs of disabled persons constitutes unlawful disability-based discrimination – even though such services may not be needed by non-disabled individuals – because such segregation perpetuates their status as second-class citizens unfit for community life. As the Third Circuit explained in holding that the unnecessary segregation of disabled persons violates Title II of the ADA, “the ADA is intended to ensure that qualified individuals receive services in a manner consistent with basic human dignity rather than a manner that shunts them aside, hides, and ignores them.” *Helen*

*L.*, 46 F.3d at 335; see also *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 461-64, 105 S. Ct. 3249, 3265-67, 87 L. Ed. 2d 313 (1985) (Marshall, J., concurring in part and dissenting in part) (surveying history of “segregation and discrimination” against mentally retarded persons).<sup>6</sup>

Further, the State’s position is inconsistent with Congress’ direction to promulgate regulations consistent with the § 504 coordination regulations. These regulations impose a duty to provide the most integrated services

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<sup>6</sup> Nothing in the Supreme Court’s decision in *Traynor v. Turnage*, 485 U.S. 535, 108 S. Ct. 1372, 99 L. Ed. 2d 618 (1988), is to the contrary. In *Traynor*, the Court held that § 504 of the Rehabilitation Act did not impliedly repeal an Act of Congress permitting veterans to delay using their “GI Bill” educational benefits past the statutory time limit because of a disability that was not the result of their own willful misconduct. In upholding the willful misconduct limitation, the Court found “nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons,” *id.* at 549, 108 S. Ct. at 1382-83, holding that Congress could choose to deny the benefit to veterans “because they engaged in some degree of wilfulness in the conduct that caused them to become disabled.” *Id.* at 550, 108 S. Ct. at 1383. Here, the issue is not whether benefits accorded to one group of disabled persons must be extended to all others, without regard to the individual’s responsibility for the conduct that caused the disability, but whether a State may provide services to individuals with disabilities in an unnecessarily segregated setting in the face of a clear congressional mandate requiring integrated services. Nothing in *Traynor* requires us to validate the unnecessary segregation at issue here. See *Helen L.*, 46 F.3d at 335-36; *Messier*, 916 F.Supp. at 142 n. 7; *Martin v. Voinovich*, 840 F.Supp. 1175, 1191 (S.D. Ohio 1993).

appropriate irrespective of any difference between services provided to individuals with disabilities and individuals without disabilities. Under the § 504 coordination regulations, no showing of differential treatment is required; the integration regulation, on its face, applies to all services provided by a public entity. Significantly, Congress did not require the Attorney General to follow other agency regulations that require integration only where differential treatment exists between individuals with disabilities and individuals without disabilities. See 45 C.F.R. § 84.4(b)(2) (1997) (Department of Health and Human Services) (requiring recipients of federal financial assistance from the agency to "afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement [as nonhandicapped persons], in the most integrated setting appropriate to the person's needs"); see also 34 C.F.R. § 104.4(b)(2) (1997) (Department of Education) (same). In making this choice, Congress decided that the unnecessary segregation of individuals with disabilities violates the ADA even absent a showing of differential treatment between individuals with disabilities and nondisabled persons. The State's position would effectively nullify Congress' choice to mandate the more demanding integration requirement contained in the § 504 coordination regulations.

Furthermore, a separate section of both the § 504 coordination regulations and the ADA Title II regulations prohibits a public entity from providing "different or separate" services to individuals with disabilities or a class of individuals with disabilities from those provided to other persons unless necessary to provide qualified

disabled individuals with services "that are as effective as those provided to others." 28 C.F.R. § 35.130(b)(1)(iv); 28 C.F.R. § 41.51(b)(1)(iv). The State's claim that § 35.130(d) also requires a showing of differential treatment between disabled and nondisabled persons would render the prohibitions contained in § 35.130(b)(1)(iv) redundant – an interpretation we must strive to avoid. See *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 837, 108 S. Ct. 2182, 2189, 100 L. Ed. 2d 836 (1988) (declining "to adopt an interpretation of a congressional enactment which renders superfluous another portion of that same law"); *Cammarano v. United States*, 358 U.S. 498, 505, 79 S. Ct. 524, 529, 3 L. Ed. 2d 462 (1959) (rejecting construction of regulation that would render a phrase "pure surplusage").

Moreover, the State's interpretation of Title II would undermine the congressional intent to end the exclusion and segregation of individuals with disabilities, as expressed in § 12101 and the ADA's legislative history. In light of Congress' recognition that "discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization," § 12101(a)(3), the State's interpretation of Title II runs directly counter to Congress' stated purposes and must be rejected. See *McNely v. Ocala Star-Banner Corp.*, 99 F.3d 1068, 1074 (11th Cir. 1996) (rejecting interpretation of the ADA because it "cannot be reconciled with . . . [the Act's] stated purpose"), cert. denied, \_\_\_ U.S. \_\_\_, 117 S. Ct. 1819, 137 L. Ed. 2d 1028 (1997). As the Third Circuit pointed out in *Helen L.*, "[i]f Congress were only concerned about disparate treatment of the disabled as compared to their nondisabled counterparts, this statement would be a non



sequitur as only disabled persons are institutionalized." 46 F.3d at 336.

Further, while the State did not deny L.C. and E.W. community-based placements out of a malevolent intent to segregate them from the community, their indifference to L.C. and E.W.'s needs – manifested by their refusal to place them in the community while recognizing the propriety of such a placement – is exactly the kind of conduct that the ADA was designed to prevent. In *Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712, 83 L. Ed. 2d 661 (1985), surveying the legislative history of the Rehabilitation Act, the precursor of the ADA, the Supreme Court explained that Congress sought to do far more than merely outlaw invidious discrimination against the handicapped.

Discrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of thoughtlessness and indifference – of benign neglect. Thus, Representative Vanik . . . described the treatment of the handicapped as one [sic] the country's "most shameful oversights," which caused the handicapped to live among society "shunted aside, hidden, and ignored." . . . Federal agencies and commentators on the plight of the handicapped similarly have found that discrimination against the handicapped is primarily the result of apathetic attitudes rather than affirmative animus.

*Id.* at 295-96, 105 S. Ct. at 717 (footnotes omitted) (citations omitted). Indeed, Justice Marshall's opinion for the Court made clear that "much of the conduct that Congress sought to alter in passing the Rehabilitation Act

would be difficult if not impossible to reach were the Act construed to proscribe only conduct fueled by a discriminatory intent." *Id.* at 296-97, 105 S. Ct. at 718. These same concerns underlie the ADA. "[T]he ADA attempts to eliminate the effects of that 'benign neglect,' 'apathy,' and 'indifference.'" *Helen L.*, 46 F.3d at 335; see also H.R.Rep. No. 101-485, pt. 3 at 50, reprinted in 1990 U.S.C.C.A.N. at 473 (" 'The goal is to eradicate the invisibility of the handicapped.' ") (quoting *ADAPT v. Skinner*, 881 F.2d 1184, 1204 (3d Cir. 1989) (en banc) (Mansmann, J., concurring in part and dissenting in part)). The State's failure to place L.C. and E.W. in the community thus falls squarely within the ADA's ban on disability-based discrimination.

Nor do any of the cases cited by the State require a different conclusion. The State relies heavily on our en banc decision in *S.H. v. Edwards*, 886 F.2d 292 (11th Cir. 1989) (en banc), as well as several cases decided by other circuits, see *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. 1990); *Clark v. Cohen*, 794 F.2d 79 (3d Cir. 1986); *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983). But nothing in *S.H.* or these other cases remotely touches on the issues presented by this appeal. While it is true that we generally look to Rehabilitation Act precedents in construing the ADA, see *Duckett*, 120 F.3d at 1225 n. 1, none of the cases cited by the State involved claims under the express integration regulation of either the ADA or the § 504 coordination regulations, and therefore, those cases are inapposite here. See *Helen L.*, 46 F.3d at 333-34 (distinguishing prior Rehabilitation Act precedent on this ground).

In *S.H.*, for example, we considered " 'plaintiffs' claims for relief in the nature of habilitation in the least

restrictive environment in accordance with the recommendation of professional treatment staff.' " *S.H.*, 886 F.2d at 293. *S.H.* did not involve the integration regulation of either § 504 of the Rehabilitation Act or the ADA, or a claim that plaintiffs had been unnecessarily segregated. Instead, plaintiffs' only statutory claim was that they had been impermissibly denied habilitation reviews. The district court denied this claim, finding that the legislature's use of a chronological bright-line to trigger habilitation reviews did not evidence discrimination solely because of disability. See *S.H. v. Edwards*, 860 F.2d 1045, 1052 (11th Cir. 1988) (district court opinion attached as appendix A). It is far from clear whether our two paragraph en banc decision even considered plaintiffs' Rehabilitation Act claim.

Finally, we also reject the State's suggestion that L.C. and E.W.'s ADA claim must fail because the denial of community-based placements was based on a lack of funds, not on L.C. and E.W.'s disabilities. Under the ADA, as under Title VII of the Civil Rights Act, "the absence of a malevolent motive does not convert a facially discriminatory policy into a neutral policy. . . ." *International Union, UAW v. Johnson Controls*, 499 U.S. 187, 199, 111 S. Ct. 1196, 1203-04, 113 L. Ed. 2d 158 (1991). Even if the State failed to place L.C. and E.W. in the community because of a lack of funding, this motive does not lessen the "discriminatory character" of their segregation. *Id.* Moreover, the plain language of the ADA's Title II regulations, as well as the ADA's legislative history, make clear that Congress wanted to permit a cost defense only in the most limited of circumstances. The ADA's Title II regulations permit a state to justify its failure to

make reasonable accommodations for individuals with disabilities where those accommodations "would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7).<sup>7</sup> As the House Judiciary report explained,

The fact that it is more convenient, either administratively or fiscally, to provide services in a segregated manner, does not constitute a valid justification for separate or different services under Section 504 of the Rehabilitation Act, or under this title. . . . The existence of such programs can never be used as a basis to . . . refuse to provide an accommodation in a regular setting.

H.R.Rep. No. 101-485, pt. 3 at 50, reprinted in 1990 U.S.C.C.A.N. at 473. The State's argument that its lack of funds makes its refusal to provide integrated services non-discriminatory is inconsistent with the ADA's statutory scheme and would permit a public entity to justify its refusal to comply with the ADA by asserting that it lacked the money to do so.

We emphasize that our holding does not mandate the deinstitutionalization of individuals with disabilities. Instead, we hold that where, as here, a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting – the most integrated setting appropriate to that patient's needs. Where there is no such finding, on the other hand, nothing in the ADA requires the deinstitutionalization of that patient.

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<sup>7</sup> We consider the applicability of this defense in part IV.



## III.

The State also argues that the district court erred in granting summary judgment to E.W. because there is a disputed issue of fact regarding whether E.W. could be placed in a community-based treatment program. We review the district court's grant of summary judgment de novo, applying the same standards as the district court. *Harris*, 102 F.3d at 518. Summary judgment is appropriate if the pleadings, depositions, and affidavits show that no genuine issue of material fact exists for trial and that the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S. Ct. 2548, 2552, 91 L. Ed. 2d 265 (1986). We must view all evidence and all factual inferences reasonably drawn from the evidence in the light most favorable to the nonmoving party. *Harris*, 102 F.3d at 519.

The State concedes that, at times during the course of this litigation, its own experts found that E.W. could be placed in a community treatment program. However, it claims that because, at other times, those experts maintained that E.W. should receive treatment in an institutionalized setting, a genuine issue of material fact exists as to whether community-based treatment was a possibility for E.W. In particular, the State points to the statements of Dr. Gary DeBacher, the chief of the Psychology staff at GRH-A, Joseph Steed, a behavioral specialist with the Fulton County Regional Board, and Gloria Sheppard, a member of the Board's Comprehensive Evaluation Team. As the State argues, these experts found that E.W. could not be placed in the community at certain times during this litigation. At the same time, however, these experts testified that a community-based placement

would be appropriate for E.W. once her condition improved, so long as the community treatment program provided her with the necessary level of care and supervision.<sup>8</sup>

In light of the testimony and considering the record as a whole, we reject the State's argument that the district court's grant of summary judgment was in error. All the experts, including E.W.'s treating physician, were unanimous that E.W. could be appropriately placed in a community-based treatment program, provided that it could give E.W. the level of care and supervision she needed.<sup>9</sup> The State has not suggested that such placements were not available to E.W. Indeed, they were able to find such a placement for E.W. after the district court's judgment.

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<sup>8</sup> The State also points to E.W.'s hospitalization at the Central State Hospital in Milledgeville, Georgia and at Grady Memorial Hospital in Atlanta in late 1996 to support the conclusion that E.W. could not be placed in the community. At that time, E.W.'s kidney functions were compromised, requiring surgery in the hospital. Although prior to the surgery, one of the State's experts, Dr. George Echols, was uncertain whether E.W. could be placed in the community after the surgery, the surgeon who performed the operation testified after the surgery that E.W.'s medical problems did not require her to remain in a state hospital.

<sup>9</sup> In early 1995, the experts at GRH-A themselves recognized that E.W. could be placed outside GRH-A. They repeatedly placed her in personal care homes, providing her with a community setting for her treatment. She was not placed, however, in a community setting with the appropriate level of monitoring, and, as a result, she returned to GRH-A after extremely short stays in the community.

We do not suggest that should a trial court find that a patient, for medical reasons, needs institutionalized care, must nonetheless order placement in a community-based treatment program. We recognize that the determination whether a patient can be appropriately placed in a community-based treatment program is a fluid one, subject to change as the patient's medical condition improves or worsens. Over the course of litigation, there may be times that a patient can be treated in the community, and others where an institutional placement is necessary. But where, as here, the evidence is clear that all the experts agree that, at a given time, the patient could be treated in a more integrated setting, the ADA mandates that it do so at that time unless placing that individual would constitute a fundamental alteration in the state's provision of services. Nothing in the ADA, however, forbids a state from moving a patient back to an institutionalized treatment setting, as the patient's condition necessitates.

Under these principles, the district court correctly denied the State's motion for summary judgment. Summary judgment is not precluded here by the fact that, at earlier times in the litigation, some of the State's experts opined that E.W. could not be placed in the community immediately. None of the State's experts concluded that E.W. needed to be placed at GRH-A on a long-term basis. At most, they believed that, in the short term, continued hospitalization was necessary in order to permit E.W. to make the transition to a community-based living arrangement in a group home. Although one of the State's experts, Joseph Steed, expressed concerns that E.W. would not progress to the point where she could be

placed in the community, the evidence in the record shows that, in the spring and summer of 1996 – after Steed's initial assessment as well as the others cited by the State – GRH-A attempted to find a community placement for E.W., but could not because there were no available state Medicaid waiver funds for such a placement.

Accordingly, because the State's own professionals agreed that E.W. could be placed in a less segregated setting, the State has failed to demonstrate that there is a material issue of fact for trial as required by Fed.R.Civ.P. 56. Accordingly, the grant of summary judgment was not in error.

#### IV.

In Part II we rejected the State's argument that it complied with the ADA in this case because the denial of community placements to L.C. and E.W. was based on the State's lack of funds, not on plaintiffs' disabilities. We must now address whether the lack of available funding provides the State a defense to plaintiffs' ADA claim.

Notwithstanding that under the ADA and its Title II regulations the State has a duty to provide integrated services when the patient's care warrants such services, that duty is not absolute. As discussed above, the State need not provide these services if to do so would require a fundamental alteration in its programs. Under Title II, "[a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that



making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7).

L.C. and E.W. have demonstrated that the State may reasonably modify its provision of services by providing treatment to them in an integrated setting. L.C. and E.W. point out that, under Georgia law, the State has the authority to transfer funds between institutional and community-based treatment programs based on need. O.C.G.A. § 37-2-5.1(c)(3) (1995). They also note that, under the federal government's Medicaid waiver program, the State may spend Medicaid funds to provide community-based care to disabled persons who would otherwise be eligible for institutionalized care. The federal government has authorized matching federal dollars for over 2100 patients in Georgia, but, in 1996, the State used only 700 of these slots. Finally, they argue that the State can provide integrated community-based services at significantly less cost than institutionalized care.

The availability of these alternate sources of funding makes L.C. and E.W.'s request for modification of the State's program of providing services to disabled persons a reasonable one " 'in the run of cases.' " *Willis*, 108 F.3d at 286 n. 2 (quoting *Barth v. Gelb*, 303 U.S. App. D.C. 211, 2 F.3d 1180, 1187 (D.C. Cir. 1993)). Accordingly, it is the State's duty to demonstrate that providing treatment to L.C. and E.W. fundamentally alters the nature of the service it provides " 'in the context of the particular agency's operations.' " *Id.*; *Helen L.*, 46 F.3d at 337; H.R.Rep. No. 101-485, pt. 3 at 51, reprinted in 1990 U.S.C.C.A.N. at 474 (noting importance of "size and budget" of the particular agency).

The State does not argue that the relief requested by L.C. and E.W. will effect a fundamental alteration by requiring it to dismantle its provision of institutionalized care to individuals with disabilities. Instead, the State argues that it lacks the funds to provide community-based services to L.C. and E.W. The district court rejected this argument, reasoning that the State could provide community-based services to L.C. and E.W. at less cost than providing institutional care for them at GRH-A. Accordingly, it found that the State's purported lack of funds to provide community-based services to L.C. and E.W. was insufficient as a matter of law to establish that providing community-based care to plaintiffs would constitute a fundamental alteration.

Under the ADA, as with other federal statutes, "inadequate state appropriations do not excuse noncompliance" with federal law. *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 396 (5th Cir. 1980) (Medicaid Act); see also *Doe v. Chiles*, 136 F.3d 709, 722 (11th Cir. 1998) (same); *Tallahassee Mem. Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 704 (11th Cir. 1997) (same). Having chosen to provide services to individuals with disabilities, the State – both the state officials charged with formulating the budget as well as the state agencies responsible for mental health services – must act "in a manner [that] comports with the requirements of [the ADA]." *Helen L.*, 46 F.3d at 339.

Our cases make clear that the ADA does not permit the State to justify its discriminatory treatment of individuals with disabilities on the grounds that providing non-discriminatory treatment will require additional expenditures of state funds. We recognized this principle in

*United States v. Board of Trustees for University of Alabama*, 908 F.2d 740 (11th Cir. 1990). There, we held that, considering the size of the University of Alabama's transportation budget, the University failed to show that an additional expenditure of \$15,000 to modify its bus system to reasonably accommodate individuals with disabilities would impose an undue financial hardship. The University could not simply claim that it lacked the funds to make these modifications in its bus system; rather, it could only justify its discriminatory treatment by demonstrating that its transportation budget could not be reasonably modified to take account of the needs of the disabled. In light of its "annual transportation budget of \$1.2 million," we concluded that requiring minimal additional expenditures of \$15,000 would not "cause an undue financial burden on UAB." *Id.* at 751.

The district court did not consider whether treating L.C. and E.W. would require additional expenditures and if so, whether the State had met its burden of proving that those expenditures were unreasonable in light of the State's mental health budget. Instead, it noted that the State currently provided community-based services to individuals with disabilities and that such services could be provided at less cost than segregated services. Based on these two factors, the district court concluded that the State had failed to show that providing community-based care to L.C. and E.W. would cause a fundamental alteration.

There is evidence in the record that suggests that, because of fixed overhead costs associated with providing institutional care, the State will be able to save money

by moving patients from institutionalized care to community-based care only when it shuts down entire hospitals or hospital wings, but not when it moves one or two patients from a hospital into the community. Thus, it may be that requiring the State to treat L.C. and E.W. in a community-based program will require additional expenditure of state funds.

Nonetheless, the ADA may still require the State to expend additional funds in order to provide L.C. and E.W. with integrated services. Unless the State can prove that requiring it to make these additional expenditures would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides, the ADA requires the State to make these additional expenditures. Because the district court did not consider this question and because of the complexity of the factual issues concerning the funding for mental health services in Georgia, we remand this case to the district court for further proceedings on this issue. In determining whether the State can meet its burden of establishing a fundamental alteration, the district court should consider, among other things: (1) whether the additional expenditures necessary to treat L.C. and E.W. in community-based care would be unreasonable given the demands of the State's mental health budget; (2) whether it would be unreasonable to require the State to use additional available Medicaid waiver slots, as well as its authority under Georgia law to transfer funds from institutionalized care to community-based care, to minimize any financial burden on the State; and (3) whether any difference in the cost of providing institutional or community-based care will lessen the State's



financial burden.<sup>10</sup> This list, is, of course, not exclusive. The district court may also consider any other factors it believes are relevant to the fundamental alteration inquiry.

Accordingly, the judgment of the district court is **AFFIRMED** and the case is **REMANDED** for further proceedings consistent with this opinion.

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<sup>10</sup> We note that this case is not a class action, but a challenge brought on behalf of two individual plaintiffs. Our holding is not meant to resolve the more difficult questions of fundamental alteration that might be present in a class action suit seeking deinstitutionalization of a state hospital.

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## APPENDIX B

UNITED STATES DISTRICT COURT/  
NORTHERN DISTRICT OF GEORGIA

ATLANTA DIVISION

|                        |   |                        |
|------------------------|---|------------------------|
| L.C., by JONATHAN      | : |                        |
| ZIMRING as guardian ad | : |                        |
| litem and next friend, | : |                        |
| Plaintiff,             | : | CIVIL ACTION           |
|                        | : |                        |
| E.W., by JONATHAN      | : | 1:95-cv-1210-MHS       |
| ZIMRING as guardian ad | : | (Filed March 26, 1997) |
| litem and next friend, | : |                        |
| Plaintiff-Intervenor,  | : |                        |
|                        | : |                        |
| v.                     | : |                        |
| TOMMY OLMSTEAD,        | : |                        |
| Director of the        | : |                        |
| Department of Human    | : |                        |
| Resources, et al.,     | : |                        |
| Defendants.            | : |                        |

## ORDER

This is an action for declaratory and injunctive relief brought on behalf of two mentally retarded persons, L.C. and E.W., who have been institutionalized in a state mental hospital. They allege that under rights granted them by the Americans with Disabilities Act and the Fourteenth Amendment to the United States Constitution, they are entitled to an order requiring the state to provide them care in the "most integrated setting appropriate," which they contend is a community-based treatment program rather than a state mental hospital. Before the Court

are plaintiffs' and defendants' cross-motions for summary judgment as well as plaintiff E.W.'s motion for a preliminary injunction. The Court's rulings are summarized below.

### Background

On May 11, 1995, plaintiff L.C., a 27-year-old mentally retarded woman who has also been diagnosed as schizophrenic, filed this action challenging her continued confinement at Georgia Regional Hospital at Atlanta ("GRH-A"), a state mental institution. L.C. names as defendants the Commissioner of the Georgia Department of Human Resources, the Superintendent of GRH-A, and the Executive Director of the Fulton County Regional Board, which is responsible for the provision of mental health and mental retardation services to residents of Fulton County.

In her complaint, L.C. alleged that, despite the professional judgment of her psychiatric treatment team that she no longer required in-patient psychiatric treatment but instead needed community residential and habilitation services, defendants had continued to confine her at GRH-A. L.C. alleged that her continued unnecessary confinement violated her rights to freedom from undue restraint, minimally adequate treatment, freedom from illegal discrimination, and placement in the most integrated setting appropriate to her needs, which were guaranteed by the Fourteenth Amendment to the United States Constitution and under Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12131 *et seq.* She sought declaratory and injunctive relief requiring, *inter*

*alia*, that she be released from GRH-A into a community care residential program and provided with appropriate treatment by qualified professionals.

On or about July 27, 1995, pursuant to a consent order entered in this action, defendants discharged L.C. from GRH-A to Brook Run, a state institution for treatment of the mentally retarded. On February 12, 1996, L.C. was released from Brook Run to a community support program known as "Nyasha Hands." However, L.C. contends that she is not receiving appropriate services to support her in the community and is at high risk of having problems that will cause her to be returned to GRH-A.

Meanwhile, on January 29, 1996, the Court granted the motion to intervene as plaintiff filed by E.W., a 43-year-old mentally retarded woman who has also been diagnosed with a variety of mental disorders. Like L.C., E.W. alleged that she was confined unnecessarily and inappropriately at GRH-A and sought release into a community-based residential program.

On July 12, 1996, plaintiff E.W. moved for a preliminary injunction directing defendants to release her from GRH-A to an appropriate, integrated, community setting. On August 20, 1996, plaintiffs also filed a motion for summary judgment. On August 22, 1996, defendants filed a cross-motion for summary judgment. The Court has deferred a hearing on E.W.'s motion for a preliminary injunction pending a ruling on the parties' cross-motions for summary judgment.



### Summary Judgment Standard

Under Rule 56(c) of the Federal Rules of Civil Procedure, summary judgment is appropriate when "there is no genuine issue as to any material fact . . . and the moving party is entitled to judgment as a matter of law." In *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986), the Supreme Court held that this burden could be met if the moving party demonstrates that there is "an absence of evidence to support the non-moving party's case." *Id.* at 325. At that point, the burden shifts to the non-moving party to go beyond the pleadings and present specific evidence giving rise to a triable issue. *Id.* at 324.

In reviewing a motion for summary judgment, the Court must construe the evidence and all inferences drawn from the evidence in the light most favorable to the non-moving party. *WSB-TV v. Lee*, 842 F.2d 1266, 1270 (11th Cir. 1988). Nevertheless, "the mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no genuine issue of material fact." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

### The Parties' Contentions

Plaintiffs contend that defendants have unnecessarily institutionalized and segregated them in a mental hospital rather than placing them in an appropriate, integrated community setting, and that this constitutes unlawful discrimination on the basis of their disability in violation of the ADA. Plaintiffs also allege that defendants have failed to provide them minimally adequate treatment and

habilitation and freedom from undue restraint in violation of their rights under the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution.

Defendants contend that L.C.'s claims are moot because she is already being treated in an adequate community placement. Defendants further argue that they have not violated E.W.'s rights under the ADA because she has been denied community placement due to inadequate funding and not due to any discrimination based on her disability. Finally, defendants contend that they have not violated E.W.'s rights under the Due Process Clause because the decision to treat her at GRH-A rather than in the community was based on the exercise of professional judgment.

### Discussion

#### 1. Mootness

After this lawsuit was filed, defendants placed L.C. in a community-based support program. However, due to a funding problem, L.C. did not receive the services intended to be provided through this program for at least several months. While it appears that the funding problem has been resolved for now, given plaintiff's history of at least eighteen prior hospitalizations at GRH-A and the questionable stability of her current placement, the Court finds that there is a significant threat of L.C.'s being returned to GRH-A. The Court concludes that plaintiff's claims are not moot because they are "capable of repetition, yet evading review." *Sultenfuss v. Snow*, 35 F.3d 1494, 1498 n.5 (11th Cir. 1994); see also *Vitek v. Jones*, 445 U.S.

480, 487 (1980); *Lynch v. Baxley*, 744 F.2d 1452, 1457 (11th Cir. 1984).

## 2. ADA

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. To prove a violation of Title II, plaintiffs must show: (1) that they are "qualified individual[s] with a disability"; (2) that they were excluded from participation in or denied the benefits of some public entity's services, programs, or activities, or were otherwise discriminated against; and (3) that such discrimination was "by reason of" their disability. See *Concerned Parents to Save Dreher Park Center v. City of West Palm Beach*, 846 F. Supp. 986, 990 (S.D. Fla. 1994).

In this case, there is no dispute that plaintiffs are qualified individuals with a disability. There is also no dispute that plaintiffs can be placed in the community. As noted above, defendants have already placed L.C. in a community-based program. As for E.W., although defendants dispute whether she *should* be placed in the community, the record demonstrates that the qualified experts are unanimous in their opinion that E.W. *can* be placed in the community, and defendants concede that E.W. qualifies for community-based services.<sup>1</sup>

<sup>1</sup> In a supplemental brief, defendants take the position that a recent medical problem experienced by E.W. precludes a

Defendants argue, however, that plaintiffs have failed to prove the third element of their ADA claim, *i.e.*, that they have been discriminated against "by reason of" their disability. Defendants contend that plaintiffs have been denied community-based placements due to inadequate funding, not because of any discrimination based on their disability. The Court concludes, however, that under the ADA, unnecessary institutional segregation of the disabled constitutes discrimination *per se*, which cannot be justified by a lack of funding.

First, it is clear from the statute itself that "segregation" of individuals with disabilities is a "form[] of discrimination" that Congress intended to eliminate. 42 U.S.C. § 12101(a)(2), (3), (5). Indeed, the legislative history is replete with statements reflecting Congress's intent to prohibit unnecessary segregation of the disabled.<sup>2</sup>

Second, the regulations promulgated by the Attorney General to implement Title II plainly prohibit unnecessary institutionalization: "A public entity shall administer services, programs, and activities in the most integrated

community placement for her at this time. However, the evidence submitted by defendants does not support this conclusion. The record established that E.W.'s medical problem has been resolved by surgery and does not prevent her being placed in the community.

<sup>2</sup> For example, Senator Harkin, floor manager of the ADA in the Senate, stated that the Act "guarantees individuals with disabilities the right to be integrated into the economic and social mainstream of society; segregation and isolation by others will no longer be tolerated." 135 Cong. Rec. 19803 (1989). Plaintiffs cite numerous additional examples in their briefs.



setting appropriate to the needs of qualified individuals with disabilities."<sup>3</sup> 28 C.F.R. § 35.130(d). The regulations also require public entities to make reasonable modifications in existing programs in order to avoid discrimination: "A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7).

Finally, in a similar case, the Third Circuit rejected an argument that continued institutionalization in a nursing home was justified by a lack of funding for an attendant care program that would permit the plaintiff to live at home. *Helen L. v. DiDario*, 46 F.3d 325 (3rd Cir.), cert. denied, 116 S. Ct. 64 (1995). Holding that "the ADA and its attendant regulations clearly define unnecessary segregation as a form of illegal discrimination against the disabled," *id.* at 333 (footnote omitted), the court concluded that "since the Commonwealth has chosen to provide services to Idell S. under the ADA, it must do so in a manner which comports with the requirements of that statute." *Id.* at 339.

In this case, defendants contend that all available funds are being used to provide services to other disabled persons. However, there is no dispute that defendants

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<sup>3</sup> The "most integrated setting appropriate" is "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible. . . ." 28 C.F.R. Pt. 35, App. A.

already have existing programs providing community services to persons such as plaintiffs. It is also undisputed that defendants can provide services to plaintiffs in the community at considerably *less* cost than is required to maintain them in an institution.<sup>4</sup> Thus, defendants cannot demonstrate that any fundamental alteration of their program is required in order to serve plaintiffs appropriately in the community. The fact that it may be more convenient, either administratively or fiscally, to provide services in a segregated manner does not justify defendants' failure to comply with the ADA.

For the foregoing reasons, the Court denies defendants' motion for summary judgment and grants plaintiffs' motion for summary judgment on plaintiffs' ADA claim; declares that defendants' failure to place plaintiffs in an appropriate community-based treatment program violates the ADA; permanently enjoins defendants from further violating plaintiffs' rights under the ADA; and orders defendants to comply with the ADA by releasing E.W. to an appropriate, community-based treatment program and by providing L.C. with all appropriate services necessary to maintain her current placement in such a program. In light of this ruling, the Court denies as moot plaintiff-intervenor E.W.'s motion for a preliminary injunction.

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<sup>4</sup> The record establishes that, on an annual basis, institutional care for the mentally retarded costs more than twice as much as community care, and that the same is true for the mentally ill.

### 3. Due Process

Plaintiffs also contend that their unnecessary institutionalization by defendants and defendants' failure to place them in an appropriate community-based treatment program violates the Due Process Clause of the Fourteenth Amendment, which guarantees them the right to minimally adequate treatment and freedom from undue restraint. See *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Wyatt v. Stickney*, 334 F. Supp. 1341 (M.D. Ala. 1971). It appears, however, that this claim is rendered moot by the Court's grant of summary judgment to plaintiffs on their ADA claim.

First, having already determined that plaintiffs' continued institutionalization is unlawfully discriminatory under the ADA, it is unnecessary for the Court also to decide whether plaintiffs' institutional care is minimally adequate or unduly restrains their freedom in violation of the Fourteenth Amendment. Second, insofar as plaintiffs seek as a remedy for defendants' alleged Fourteenth Amendment violation a discharge to an appropriate community-based treatment program, the Court has already granted such relief in connection with the grant of summary judgment on their ADA claim. Finally, insofar as plaintiffs seek an order requiring defendants to provide them with appropriate habilitation and treatment by qualified professionals to prevent deterioration of their pre-existing skills and with the ultimate goal of integrating them into the mainstream of society, the Court has already granted such relief by ordering defendants to comply with the ADA by placing E.W. in an appropriate community-based treatment program and by providing

L.C. all appropriate services necessary to maintain her current placement in such a program.

Accordingly, the Court denies as moot both plaintiffs' and defendants' motions for summary judgment on plaintiffs' claims under the Fourteenth Amendment.

### Summary

The Court GRANTS defendants' motion to extend time for filing defendants' motion for summary judgment [#58-1]; DENIES IN PART and DENIES AS MOOT IN PART defendants' motion for summary judgment [#61-1]; GRANTS IN PART and DENIES AS MOOT IN PART plaintiffs' motion for summary judgment [#59-1]; and DENIES AS MOOT plaintiff-intervenor E.W.'s motion for a preliminary injunction [#50-1].

The Court DECLARES that defendants' failure to place plaintiffs in an appropriate community-based treatment program violates Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12131 *et seq.*; PERMANENTLY ENJOINS defendants from further violating plaintiffs' rights under the ADA; and ORDERS defendants to comply with the ADA by releasing plaintiff-intervenor E.W. to an appropriate, community-based treatment program and by providing plaintiff L.C. with all appropriate services necessary to maintain her current placement in such a program.

Pursuant to Federal Rule of Civil Procedure 58(2), the Court DIRECTS the clerk to enter a final judgment in this action in the form of the preceding paragraph.



IT IS SO ORDERED, this 25th day of March, 1997.

/s/ Marvin H. Shoob  
 Marvin H. Shoob,  
 Senior Judge  
 United States District Court  
 Northern District of Georgia

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**APPENDIX C**  
**IN THE UNITED STATES COURT OF APPEALS**  
**FOR THE ELEVENTH CIRCUIT**

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No. 97-8538

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L.C., by JONATHAN ZIMRING  
 as guardian ad litem and  
 next friend; E.W.,

Plaintiffs-Appellees,

versus

TOMMY OLMSTEAD, Commissioner  
 of the Department of Human  
 Resources; RICHARD FIELDS,  
 Superintendent of Georgia  
 Regional Hospital at Atlanta;  
 EARNESTINE PITTMAN, Executive  
 Director of the Fulton County  
 Regional Board, all in their  
 official capacities,

Defendants-Appellants.

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On Appeal from the United States District Court for the  
 Northern District of Georgia

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ON PETITION(S) FOR REHEARING AND SUGGES-  
TION(S) OF REHEARING EN BANC

(Opinion \_\_\_\_\_, 11 Cir., 19\_\_\_\_, \_\_\_\_\_ F.2d \_\_\_\_\_).

(Filed July 1, 1998)

Before: TJOFLAT and BARKETT, Circuit Judges, and  
PROPST\*, Senior District Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ Rosemary Barkett  
UNITED STATES CIRCUIT JUDGE

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\* Honorable Robert B. Propst, Senior U.S. District Judge for the Northern District of Alabama, sitting by designation.

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## APPENDIX D

28 C.F.R. § 35.130(d) (1997). A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

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## APPENDIX E

43 Fed. Reg. 2132, 2134 (1978) (emphasis added).

\* \* \*

The general prohibitions against discrimination on the basis of handicap set forth in § 85.51 incorporate basic principles that the Department determined, in developing its own regulation, to be inherent in section 504. First, section 504, like other nondiscrimination statutes, prohibits not only those practices that are overtly discriminatory but also those that have the effect of discriminating. And it is equal opportunity, not merely equal treatment, that is essential to the elimination of discrimination on the basis of handicap. Thus, in some situations, identical treatment of handicapped and nonhandicapped persons is not only insufficient but is itself discriminatory. On the other hand, separate or different treatment can be permitted only where necessary to ensure equal opportunity and truly effective benefits and services. Federally assisted programs and activities must thus be provided in the most *integrated* setting appropriate to the needs of participating handicapped persons.

\* \* \*

## APPENDIX F

28 C.F.R. Pt. 35, App. A, 465, 474-479 (1997) (emphasis added).

\* \* \*

Paragraph (b)(1)(iv) permits the public entity to develop separate or different aids, benefits, or services when necessary to provide individuals with disabilities with an equal opportunity to participate in or benefit from the public entity's programs or activities, but only when necessary to ensure that the aids, benefits, or services are as effective as those provided to others. Paragraph (b)(1)(iv) must be read in conjunction with paragraphs (b)(2), (d), and (e). Even when separate or different aids, benefits, or services would be more effective, paragraph (b)(2) provides that a qualified individual with a disability still has the right to choose to participate in the program that is not designed to accommodate individuals with disabilities. Paragraph (d) requires that a public entity administer services, programs, and activities in the most *integrated* setting appropriate to the needs of qualified individuals with disabilities.

Paragraph (b)(2) specifies that, notwithstanding the existence of separate or different programs or activities provided in accordance with this section, an individual with a disability shall not be denied the opportunity to participate in such programs or activities that are not separate or different. Paragraph (e), which is derived from section 501(d) of the Americans with Disabilities Act, states that nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit that he or she chooses not to accept.

Taken together, these provisions are intended to prohibit exclusion and *segregation* of individuals with disabilities and the denial of equal opportunities enjoyed by others, based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes about individuals with disabilities. Consistent with these standards, public entities are required to ensure that their actions are based on facts applicable to individuals and not on presumptions as to what a class of individuals with disabilities can or cannot do.

*Integration* is fundamental to the purposes of the Americans with Disabilities Act. Provision of *segregated* accommodations and services regulates persons with disabilities to second-class status. For example, it would be a violation of this provision to require persons with disabilities to eat in the back room of a government cafeteria or to refuse to allow a person with a disability the full use of recreation or exercise facilities because of stereotypes about the person's ability to participate.

Many commenters objected to proposed paragraphs (b)(1)(iv) and (d) as allowing continued *segregation* of individuals with disabilities. The Department recognizes that promoting *integration* of individuals with disabilities into the mainstream of society is an important objective of the ADA and agrees that, in most instances, separate programs for individuals with disabilities will not be permitted. Nevertheless, section 504 does permit separate programs in limited circumstances, and Congress clearly intended the regulations issued under title II to adopt the standards of section 504. Furthermore, Congress included authority for separate programs in the specific requirements of title III of the Act. Section 302(b)(1)(A)(iii) of the

Act provides for separate benefits in language similar to that in §35.130(b)(1)(iv), and section 302(b)(1)(B) includes the same requirement for "the most *integrated* setting appropriate" as in §35.130(d).

Even when separate programs are permitted, individuals with disabilities cannot be denied the opportunity to participate in programs that are not separate or different. This is an important and overarching principle of the Americans with Disabilities Act. Separate, special, or different programs that are designed to provide a benefit to persons with disabilities cannot be used to restrict the participation of persons with disabilities in general, *integrated* activities.

For example, a person who is blind may wish to decline participating in a special museum tour that allows persons to touch sculptures in an exhibit and instead tour the exhibit at his or her own pace with the museum's recorded tour. It is not the intent of this section to require the person who is blind to avail himself or herself of the special tour. Modified participation for persons with disabilities must be a choice, not a requirement.

In addition, it would not be a violation of this section for a public entity to offer recreational programs specially designed for children with mobility impairments. However, it would be a violation of this section if the entity then excluded these children from other recreational services for while they are qualified to participate when these services are made available to nondisabled children, or if the entity required children with disabilities to attend only designated programs.



Many commenters asked that the Department clarify a public entity's obligation within the *integrated* program when it offers a separate program but an individual with disability chooses not to participate in the separate program. It is impossible to make a blanket statement as to what level of auxiliary aids or modifications would be required in the *integrated* program. Rather, each situation must be assessed individually. The starting point is to question whether the separate program is in fact necessary or appropriate for the individual. Assuming the separate program would be appropriate for a particular individual, the extent to which that individual must be provided with modifications in the *integrated* program will depend not only on what the individual needs but also on the limitations and defenses of this part. For example, it may constitute an undue burden for a public accommodation which provides a full-time interpreter in its special guided tour for individuals with hearing impairments, to hire an additional interpreter for those individuals who choose to attend the *integrated* program. The Department cannot identify categorically the level of assistance or aid required in the *integrated* program.

\* \* \*

Paragraphs (d) and (e), previously referred to in the discussion of paragraph (b)(1)(iv) provide that the public entity must administer services, programs, and activities in the most *integrated* setting appropriate to the needs of qualified individuals with disabilities, *i.e.*, in a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible, and that persons with disabilities must be provided the option of declining to accept a particular accommodation.

\* \* \*

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2  
No. 98-536

FILED

OCT 27 1998

IN THE

OFFICE OF THE CLERK  
SUPREME COURT, U.S.

**Supreme Court of the United States**

OCTOBER TERM, 1998

•  
TOMMY OLMSTEAD, Commissioner of the Department  
of Human Resources of the State of Georgia,  
RONALD C. HOGAN, Superintendent of Georgia  
Regional Hospital/Atlanta, and  
ERNESTINE PITTMAN, Executive Director of the  
Fulton County Regional Board,

*Petitioners,*

v.

L.C. and E.W., each by JONATHAN ZIMRING  
as guardian ad litem and next friend,

*Respondents.*

•  
On Petition For A Writ Of Certiorari To The  
United States Court Of Appeals For The Eleventh Circuit

•  
**BRIEF IN OPPOSITION  
TO PETITION FOR CERTIORARI**

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**QUESTION PRESENTED**

Did the Eleventh Circuit correctly conclude that to require L.C. and E.W. to receive services in a segregated, institutional setting when each was qualified to receive appropriate services in an existing, more integrated setting violated Title II of the ADA?

## TABLE OF CONTENTS

|   | Page |
|---|------|
| QUESTION PRESENTED .....  | i    |
| TABLE OF CONTENTS .....   | ii   |
| TABLE OF AUTHORITIES .....  | iv   |
| STATEMENT OF THE CASE .....   | 1    |
| A. Claims and Facts .....   | 1    |
| B. Proceedings Below .....  | 2    |
| ARGUMENT .....  | 5    |
| I. Neither of the State's Claims Is Procedurally Postured<br>for This Court's Review .....                      | 5    |
| A. The Ruling of the Eleventh Circuit Is Not a Final<br>Decision .....  | 5    |
| B. The State's Constitutional Arguments Were Not<br>Presented and Decided Below .....                           | 6    |
| II. The Eleventh Circuit's Decision Is Correct and Does<br>Not Raise an Important Issue Warranting Certiorari . | 7    |
| A. The Decision Below Does Not Conflict with<br>That of Any Other Federal Court of Appeals ....                 | 7    |

|   |    |
|---|----|
| 1. <i>The Two Courts of Appeals That Have<br/>Decided Whether Unnecessary Segregation Is<br/>Discrimination Under the ADA Reached the<br/>Same Conclusion</i> .....     | 7  |
| 2. <i>Petitioners Cite to Irrelevant Cases Decided<br/>Under the Rehabilitation Act of 1973 To Create<br/>a False "Conflict"</i> .....                                  | 8  |
| B. The Court of Appeals Simply Applied a<br>Congressionally-Mandated Regulation to the<br>Undisputed Facts .....  | 11 |
| III. Even If It Had Been Properly Asserted Below,<br>Petitioners' Constitutional Claim Would Not Be<br>Certworthy .....   | 14 |
| A. In This Case, Any Opinion as to the ADA's Validity<br>Under Section Five of the Fourteenth Amendment<br>Would Merely Be Advisory .....                               | 14 |
| B. In Any Event, Every Court of Appeals To<br>Consider the Issue Has Held That the ADA Does<br>Not Exceed Congress's Power To Enforce the<br>Fourteenth Amendment ..... | 15 |
| CONCLUSION .....  | 22 |



## TABLE OF AUTHORITIES

|  | Page           |
|--|----------------|
| <b>CASES:</b>  |                |
| <i>Alsbrook v. City of Maumelle</i> , 1998 U.S. App. LEXIS<br>22112 (8th Cir. Sept. 11, 1998) .....                    | 16,21          |
| <i>American Constr. Co. v. Jacksonville, T. &amp; K. W. Ry.</i> ,<br>148 U.S. 372 (1893) .....                         | 5              |
| <i>Armstrong v. Wilson</i> , 124 F.3d 1019 (9th Cir. 1997) ....  | 16             |
| <i>Autio v. AFSCME, Local 3139</i> , 140 F.3d 802 (8th Cir.<br>1998) .....   | 17             |
| <i>Autio v. AFSCME, Local 3139</i> , 1998 U.S. App. LEXIS<br>24907 (8th Cir. Oct. 5, 1998) .....                       | 17             |
| <i>Auer v. Robbins</i> , 117 S. Ct. 905 (1997) .....   | 13             |
| <i>Bragdon v. Abbott</i> , 118 S. Ct. 2196 (1998) .....  | 13             |
| <i>Brotherhood of Locomotive Firemen &amp; Enginemen v.<br/>Bangor &amp; Aroostook R.R.</i> , 389 U.S. 327 (1967) .... | 5              |
| <i>Cable v. Department of Developmental Servs.</i> , 973 F. Supp.<br>937 (C.D. Cal. 1997) .....                        | 10             |
| <i>Charles Q. v. Houstoun</i> , 1997 U.S. Dist. LEXIS 17305<br>(M.D. Pa. Sept. 30, 1997) .....                         | 10             |
| <i>City of Boerne v. Flores</i> , 117 S. Ct. 2157 (1997) .....   | 15,16<br>20,21 |

|   |                |
|---|----------------|
| <i>City of Cleburne v. Cleburne Living Ctr., Inc.</i> , 473<br>U.S. 432 (1985) .....  | 17             |
| <i>Clark v. California Dep't of Corrections</i> , 123 F.3d<br>1267 (9th Cir. 1997), <i>cert. denied</i> , 118 S. Ct.<br>2340 (1998) .....     | 17,20          |
| <i>Clark v. Cohen</i> , 794 F.2d 79 (3rd Cir. 1985) .....   | 8              |
| <i>Conner v. Branstad</i> , 839 F. Supp. 1346 (S.D. Iowa<br>1993) .....   | 9              |
| <i>Contractors Ass'n v. City of Philadelphia</i> , 6 F.3d 990<br>(3d Cir. 1993) .....   | 19             |
| <i>Coolbaugh v. Louisiana</i> , 136 F.3d 430 (5th Cir.),<br><i>cert. denied</i> , 67 U.S.L.W. 3230 (U.S. Oct. 5, 1998)<br>(No. 97-1941) ..... | 17,19<br>20,21 |
| <i>Crawford v. Indiana Dep't of Corrections</i> , 115 F.3d 481<br>(7th Cir. 1997) .....   | 17,18          |
| <i>Employment Division, Department of Human Resources v.<br/>Smith</i> , 494 U.S. 872 (1990) .....  | 15             |
| <i>Green v. Mansour</i> , 474 U.S. 64 (1985) .....  | 16             |
| <i>Hamilton-Brown Shoe Co. v. Wolf Bros. &amp; Co.</i> , 240<br>U.S. 251 (1916) .....   | 5              |
| <i>Heart of Atlanta Motel, Inc. v. United States</i> , 379 U.S.<br>241 (1964) .....   | 14             |

|  |        |
|--|--------|
| <i>Helen L. v. DiDario</i> , 46 F.3d 325 (3d Cir.), cert. denied,<br>516 U.S. 813 (1995) .....                   | 7,9    |
| <i>Heller v. Doe</i> , 509 U.S. 312 (1993) .....   | 19     |
| <i>Kathleen S. v. Department of Pub. Welfare</i> , 1998 U.S.<br>Dist. LEXIS 11819 (E.D. Pa. July 30, 1998) ..... | 10     |
| <i>Kimel v. Florida Bd. of Regents</i> , 139 F.3d 1426 (11th<br>Cir. 1998) .....                                 | 17,19  |
| <i>L.C. v. Olmstead</i> , 138 F.3d 893 (11th Cir. 1998) ...  | passim |
| <i>Martin v. Occupational Safety &amp; Health Review Comm'n</i> ,<br>499 U.S. 144 (1991) .....                   | 13     |
| <i>Messier v. Southbury Training Sch.</i> , 916 F. Supp. 133<br>(D. Conn. 1996) .....                            | 10     |
| <i>P.C. v. McLaughlin</i> , 913 F.2d 1033 (2d Cir. 1990) .....   | 9      |
| <i>Pennsylvania Dep't of Corrections v. Yeskey</i> , 118<br>S. Ct. 1952 (1998) .....                             | 6      |
| <i>Phillips v. Thompson</i> , 715 F.2d 365 (7th Cir. 1983) .....   | 9      |
| <i>S.H. v. Edwards</i> , 886 F.2d 292 (11th Cir. 1989) .....   | 8      |
| <i>Seminole Tribe v. Florida</i> , 517 U.S. 44 (1996) .....  | 16     |
| <i>Taylor v. Freeland &amp; Kronz</i> , 503 U.S. 638 (1992) .....  | 7      |
| <i>United States v. Atkinson</i> , 297 U.S. 157 (1936) .....   | 6      |

|   |    |
|---|----|
| <i>United States v. Carolene Products Co.</i> , 304 U.S. 144<br>(1938) .....        | 18 |
| <i>Williams v. Secretary of Exec. Office</i> , 609 N.E.2d 447<br>(Mass. 1993) ..... | 9  |
| <i>Williams v. Wasserman</i> , 937 F. Supp. 524 (D. Md.<br>1996) .....              | 10 |
| <i>Youakim v. Miller</i> , 425 U.S. 231 (1976) .....                                | 6  |

## STATUTES

|                                      |    |
|--------------------------------------|----|
| 42 U.S.C. § 12101(a) (1995) .....    | 20 |
| 42 U.S.C. § 12101(a)(3) (1995) ..... | 12 |
| 42 U.S.C. § 12101(a)(7) (1994) ..... | 18 |
| 42 U.S.C. § 12101(b)(4) (1995) ..... | 14 |

## OTHER AUTHORITIES

|                             |    |
|-----------------------------|----|
| 28 C.F.R. § 35.130(d) ..... | 3  |
| 28 C.F.R. § 41.51(d) .....  | 11 |



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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1998

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TOMMY OLMSTEAD, Commissioner of the Department  
Of Human Resources of the State of Georgia,  
RONALD C. HOGAN, Superintendent of Georgia  
Regional Hospital/Atlanta, and  
ERNESTINE PITTMAN, Executive Director of the  
Fulton County Regional Board,  
*Petitioners,*

v.

L.C. and E.W., each by JONATHAN ZIMRING  
as guardian ad litem and next friend,  
*Respondents.*

---

**BRIEF IN OPPOSITION  
TO PETITION FOR CERTIORARI  
FOR RESPONDENTS L.C. AND E.W.,  
each by JONATHAN ZIMRING  
as guardian ad litem and next friend**

---

**STATEMENT OF THE CASE**

**A. Claims and Facts**

Petitioners have misstated several facts. First, Respondents did not claim as stated by Petitioners that the Americans with Disabilities Act ("ADA") "required the

provision of [community-based] . . . treatment.” (Pet. at 3.)<sup>1</sup> Respondents claimed only that the provision of services by a public entity in a segregated setting was discriminatory if the disabled person qualified for an existing program in a more integrated setting.

Second, although Petitioners repeatedly assert that the State lacked funding to place the Respondents in a community-based setting, (Pet. at 3-4.) the record reveals other more pernicious reasons why Respondents were not provided with disability services in an appropriate, integrated setting. Contrary to the Petitioners’ misleading suggestion that L.C. and E.W. were provided with community placements “as funding became available” — as if that result would have followed as a matter of routine had this litigation not been commenced — the undisputed facts show that, in L.C.’s case, her treatment staff was discouraged from pursuing the very program where she was placed after this case was filed. The Petitioners did not contend until this litigation that funds were unavailable to place L.C. Similarly, Petitioners never contended that the State lacked the funds to provide care for E.W. until after she joined this suit.

## B. Proceedings Below

As noted in the petition, the Court of Appeals<sup>2</sup> based its opinion in this case in part on a regulation under the ADA

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<sup>1</sup> References to the Petition will be cited as “Pet. at \_\_\_\_.” References to the materials included in Petitioners’ appendix will be cited as “Pet. App. at \_\_\_\_.” Finally, references to the materials included in Respondents’ Appendix attached hereto will be cited as “Resp. App. at \_\_\_\_.”

<sup>2</sup> The panel consisted of Circuit Judges Tjoflat and Barkett and District Judge Propst (sitting by designation).

promulgated by the Department of Justice.<sup>3</sup> *L.C. v. Olmstead*, 138 F.3d 893, 896-97 (11th Cir. 1998). That regulation, which is referred to by the court as the integration regulation, requires that “[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d). The court concluded that “[t]here can be little question that the plain language of § 35.130(d) prohibits a state from providing services to individuals with disabilities in an unnecessarily segregated setting.” 138 F.3d at 897. In reaching its decision, the Court of Appeals found that the integration regulation was consistent with specific congressional findings<sup>4</sup> and the legislative history of the ADA. *Id.* at 898. Furthermore, the court concluded that the integration regulation was consistent with the “congressional mandate” in § 12134(b) that regulations be “consistent with this chapter and with the coordination regulations under part 41 of title 28, Code of Federal Regulations . . . applicable to recipients of Federal financial assistance under [section 504 of the Rehabilitation Act].” 138 F.3d at 896 (quoting 42 U.S.C. § 12134(b)).

Congress’ decision to incorporate the § 504 coordination regulations is particularly significant here. The Attorney General’s § 504 coordination regulations mandate that recipients of federal

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<sup>3</sup> The Department of Justice took part as amicus curiae in the Eleventh Circuit.

<sup>4</sup> For example, as the Court of Appeals noted, Congress found that “discrimination against individuals with disabilities persists in a wide variety of areas of social life, including ‘institutionalization,’ 42 U.S.C. § 12101(a)(3) (1995), and that ‘individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion . . . [and] segregation . . .’ 42 U.S.C. § 12101(a)(5).” *L.C.*, 138 F.3d at 898.



financial assistance “administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.” 28 C.F.R. § 41.51(d) (1997) (emphasis added). By requiring the Attorney General to follow the § 504 coordination regulations — including the explicit integration requirement — Congress expressly mandated that individuals with disabilities receive public services in the most integrated setting appropriate to their needs. Conforming to this mandate, § 35.130(d) tracks this very language.

*Id.* at 897-98.

After reviewing the specific facts concerning L.C. and E.W., the court determined that the confinement of L.C. and E.W. to a state mental hospital was discriminatory in violation of the integration regulation. *Id.* at 902. The court found that summary judgment was properly granted since all the experts agreed that Respondents could be appropriately treated in less segregated environments. *Id.* at 903. The court held that the application of the integration regulation to these facts was appropriate and consistent with the Department of Justice’s interpretation of the regulation. *Id.* at 898.

Petitioners repeatedly misstate the court’s holding as a finding that institutionalization constitutes “discrimination *per se*” (Pet. at 8, 10) and assert without basis that the decision grants a “*per se* right to community placement.” (Pet. at 15.) The Court of Appeals’ decision does not suggest either result. Rather, it ensures that L.C. and E.W. will not be unnecessarily segregated if they are qualified for appropriate services in a more integrated, existing program. *L.C.*, 138 F.3d at 900 & n.6. At the same time, the decision is clear that the ADA would not prevent their re-institutionalization if necessary. *Id.* at 903.

Additionally, the remand ordered by the Court of Appeals provides the State with the opportunity to show that accommodating these two individuals with integrated services would require unreasonable expenditures. *Id.* at 905.

## ARGUMENT

### I. Neither of the State’s Claims Is Procedurally Postured for This Court’s Review.

#### A. The Ruling of the Eleventh Circuit Is Not a Final Decision.

The Court of Appeals did not issue a final ruling in this case. Instead, the Eleventh Circuit remanded this action to the district court for additional findings on the State’s principal defense that additional funds would be required for L.C. and E.W.’s care in a less segregated setting and that the expenditure of those funds would cause a “fundamental alteration” in its programs. *L.C.*, 138 F.3d at 904-05. “[B]ecause the Court of Appeals remanded the case, it is not yet ripe for review by this Court.” *Brotherhood of Locomotive Firemen & Enginemen v. Bangor & Aroostook R.R.*, 389 U.S. 327, 328 (1967). “[E]xcept in extraordinary cases, the writ is not issued until final decree.” *Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916). The writ should be denied “unless it is necessary to prevent extraordinary inconvenience and embarrassment in the conduct of the cause.” *American Constr. Co. v. Jacksonville, T. & K. W. Ry.*, 148 U.S. 372, 384 (1893). The State has suggested no reason whatsoever why this case should be heard at this juncture despite the remand to the district court.

**B. The State's Constitutional Arguments Were Not Presented and Decided Below.**

The State of Georgia raised absolutely no argument in the district court that Congress might lack enforcement power under section five of the Fourteenth Amendment to forbid discriminatory institutionalization. Needless to say, the district court did not rule on any such issue. (Pet. App. 31a-42a.) The State gave scant mention to any section five issue in its brief to the Court of Appeals, mentioning it in only a single, abbreviated paragraph. (Resp. App. at A-2.) Like the district court, the Court of Appeals in its opinion made no mention of section five. (Pet. App. 1a-30a.)

This Court should deny review of the section five issue. In deciding a case in a virtually identical procedural posture, this Court remarked: "We do not address another issue presented by petitioners: whether application of the ADA to [respondents] is a constitutional exercise of Congress's power under . . . § 5 of the Fourteenth Amendment. Petitioners raise this question [here], but it was addressed by neither the District Court nor the Court of Appeals." *Pennsylvania Dep't of Corrections v. Yeskey*, 118 S. Ct. 1952, 1956 (1998) (citations omitted).

This Court traditionally denies review of questions not presented and decided below. Where, as here, no issue is raised in the district court, review is denied unless error is "obvious, or . . . seriously affect[s] the fairness, integrity or public reputation of judicial proceedings." *United States v. Atkinson*, 297 U.S. 157, 160 (1936). Here the State also failed to obtain a section five ruling in the Court of Appeals. "Ordinarily, this Court does not decide questions not raised or resolved in the lower court." *Youakim v. Miller*, 425 U.S. 231, 234 (1976). "These principles help to maintain the integrity of the process

of certiorari." *Taylor v. Freeland & Kronz*, 503 U.S. 638, 646 (1992). Once again, the State has offered no reason why this Court should deviate from its usual denial of procedurally inapt cases.

**II. The Eleventh Circuit's Decision Is Correct and Does Not Raise an Important Issue Warranting Certiorari.**

**A. The Decision Below Does Not Conflict with That of Any Other Federal Court of Appeals.**

1. *The Two Courts of Appeals That Have Decided Whether Unnecessary Segregation Is Discrimination Under the ADA Reached the Same Conclusion.*

There is absolutely no conflict in the circuits on this issue. The Eleventh Circuit in this case and the Third Circuit in *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir.), *cert. denied*, 516 U.S. 813 (1995) agree that the ADA prohibits public entities from requiring a disabled person to receive disability services in a segregated program if the individual's needs can be met in an existing, appropriate, more integrated program. In *Helen L.*, the Third Circuit held that "the ADA and its attendant regulations clearly define unnecessary segregation as a form of illegal discrimination against the disabled." *Id.* at 333. This conclusion was reached after a careful investigation of the ADA's predecessor, § 504 of the Rehabilitation Act of 1973, and a well-reasoned review of the ADA, its legislative history, its regulations, and agency interpretation of those regulations.



The Eleventh Circuit in this case reached the same conclusion. Like the court in *Helen L.*,<sup>5</sup> the Eleventh Circuit concluded that the ADA and its legislative history, as well as its implementing regulations and their agency interpretation, "plainly prohibit a state from treating individuals with disabilities in a segregated environment where a more integrated setting would be appropriate." 138 F.3d at 897.

2. *Petitioners Cite to Irrelevant Cases Decided Under the Rehabilitation Act of 1973 To Create a False "Conflict."*

Petitioners' argument that a conflict exists is based on a group of cases decided under a different statute, the Rehabilitation Act of 1973. Among the cases asserted by Petitioners to conflict with the Eleventh Circuit's decision in this case are one decided by the Eleventh Circuit, *S.H. v. Edwards*, 886 F.2d 292 (11th Cir. 1989) (en banc), and one by the Third Circuit, *Clark v. Cohen*, 794 F.2d 79 (3rd Cir. 1985). Notably, neither the Eleventh Circuit in this case nor the Third Circuit in *Helen L.* were concerned that their decisions created a conflict with this circuit precedent. As stated by the Eleventh

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<sup>5</sup> Hoping to trigger alarm, Petitioners declare that "Shepard's citations showed '170 Citing References'" to *Helen L.*, (Pet. at 8 n.4) implying that other courts are running amok with what they consider to be a misguided decision. Examination of these cases, however, reveals that few made any reference to the central holding of the case. Instead, the vast majority were employment discrimination cases (ADA, Title III) and had nothing to do with the provisions of the ADA pertinent to this case (ADA, Title II). Moreover, the references to *Helen L.* were generally used to support basic propositions about the ADA (e.g.: the ADA was enacted to expand § 504; regulations promulgated by an agency are entitled to considerable weight, etc.). Finally, many of the Shepard's citations were simply multiple references to the same case citing *Helen L.*, which appeared in different reporters.

Circuit, "nothing in *S.H.* or these other cases remotely touches on the issues presented by this appeal . . . . [N]one of the cases cited by the State involved claims under the express integration regulation of either the ADA or the § 504 coordination regulations, and therefore, those cases are inapposite here." *L.C.*, 138 F.3d at 901. Similarly, the Third Circuit, referring to its own *Clark v. Cohen* decision, stated that "we were not there concerned with the integration mandate of the ADA or the Rehabilitation Act" and noted that "[t]he language of 28 C.F.R. § 35.130(d) is very different." *Helen L.*, 46 F.3d at 333.

The only two other Court of Appeals cases cited in Petitioners' string cite of supposedly conflicting decisions likewise did not involve claims under the ADA, the integration regulation, or even the § 504 coordination regulations. See *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. 1990); *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983). Petitioners' purported circuit conflict is illusory.<sup>6</sup>

Petitioners' secondary argument, that *Helen L.* has created "confusion" within the district courts, is likewise erroneous. Each of the five district court cases cited by Petitioners as illustrative of this supposed confusion is entirely consistent with *Helen L.* and the decision of the Eleventh Circuit. In three of the cases, the district courts found that the ADA prohibits a

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<sup>6</sup> Indeed, only two of the cases cited by Petitioners to support their claim of a purported "conflict" involved the ADA and its integration regulation. See *Conner v. Branstad*, 839 F. Supp. 1346 (S.D. Iowa 1993); *Williams v. Secretary of Exec. Office*, 609 N.E.2d 447 (Mass. 1993). Both are factually distinct and thus do not address the issue here. *Conner* involved a dispute regarding the qualification of the Plaintiffs for existing integrated services and a claim that the state should create services, a claim not made here. 839 F. Supp. at 1358. In *Williams*, the plaintiffs were not in segregated programs. 609 N.E.2d at 451-52.

public entity from discriminating against an individual based on the severity of her disability.<sup>7</sup> In the two remaining cases, the courts found that the ADA prohibits a public entity from discriminating against an individual by segregating her unnecessarily.<sup>8</sup> Petitioners imply that these two forms of discrimination are inconsistent and cannot both be prohibited by the ADA. Certainly, none of the cited cases held, or even implied, that such a limitation exists. As the Eleventh Circuit noted, the language and legislative history of the ADA show that Congress was concerned with both forms of discrimination. 138 F.3d at 897-902.

Petitioners concede that their experts found L.C. and E.W. to be qualified for more integrated services. Each, in fact, is receiving integrated services after years of segregated, institutional programs. Respondents have been living successfully in the community — L.C. since February 1996 and E.W. since July 1997. The State is merely seeking power to unnecessarily re-segregate them. No conflict in the circuits exists on the issue decided by the Court of Appeals in this case; therefore, there is no justification for a grant of a writ.

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<sup>7</sup> *Cable v. Department of Developmental Servs.*, 973 F. Supp. 937 (C.D. Cal. 1997); *Messier v. Southbury Training Sch.*, 916 F. Supp. 133 (D. Conn. 1996); *Williams v. Wasserman*, 937 F. Supp. 524 (D. Md. 1996).

<sup>8</sup> *Kathleen S. v. Department of Pub. Welfare*, 1998 U.S. Dist. LEXIS 11819 (E.D. Pa. July 30, 1998); *Charles Q. v. Houstoun*, 1997 U.S. Dist. LEXIS 17305 (M.D. Pa. Sept. 30, 1997).

## **B. The Court of Appeals Simply Applied a Congressionally-Mandated Regulation to the Undisputed Facts.**

As noted above, the Eleventh Circuit held that “§ 12131 of the ADA and the Department of Justice’s integration regulation, 28 C.F.R. § 35.130(d), prohibit a state from confining a disabled individual in a state-run institution where that individual could be appropriately treated in a more integrated community setting.” *L.C.*, 138 F.3d at 895-96. This case involved the application of that regulation to two disabled people who, in the unanimous view of all the experts, no longer needed to receive services in a segregated, state-run mental institution. *Id.* at 903. Petitioners assert, however, that “formal administrative interpretations” of the ADA integration regulation are inconsistent with the interpretation given the regulation by the courts below and the Department of Justice. (Pet. at 11.) This assertion ignores the difference between the coordination regulations (embraced by Congress in the ADA) and the § 504 regulations adopted by various federal agencies. There were a variety of regulations promulgated under § 504 because each federal agency promulgated its own regulations. Some required integration of disabled persons with non-disabled persons and some also required the integration of disabled persons into the most integrated program appropriate to meet the individual needs of that person. The latter was a requirement of the “coordination regulations.”<sup>9</sup>

Likewise, the preamble to the ADA regulations, cited by Petitioners, does not support their contention that the regulation

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<sup>9</sup> The § 504 coordination regulations provide that “[r]ecipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.” 28 C.F.R. § 41.51(d). (Resp. App. at A-1.)



interpreted in this case requires only integration of the disabled with the non-disabled.<sup>10</sup> Instead, the preamble addresses both aspects of the regulation. Paragraph 35.130(b) deals with the limits on separate programs. Paragraph 35.130(d), by contrast, requires that services be provided in the most appropriate, integrated setting. Even the selected sections of the preamble chosen by Petitioners make this clear:

Taken together, these provisions are intended to prohibit exclusion and *segregation* of individuals with disabilities *and* the denial of equal opportunity enjoyed by others.

*Integration* is fundamental to the purposes of the Americans with Disabilities Act. . . .

Paragraphs (d) and (e) . . . provide that the public entity must administer services, programs, and activities in the most *integrated* setting appropriate to the needs of qualified individuals with disabilities, *i.e.*, in a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible . . . .

(Pet. App. at 48a, 50a.) (second emphasis added).

Thus, the Court of Appeals correctly followed the plain language of 28 C.F.R. § 35.130(d). Moreover, the Court of

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<sup>10</sup> The Court of Appeals, in addressing the State's argument that "integration" did not apply to services which serve only disabled persons, noted that "[r]educ[ed] to its essence, the State's argument is that Title II of the ADA affords no protection to individuals with disabilities who receive public services designed only for individuals with disabilities." *L.C.*, 138 F.3d at 896.

Appeals had the benefit of the Department of Justice's own interpretation of the regulation as expressed in the Preamble and in its amicus submissions to the court. "It is well established 'that an agency's construction of its own regulations is entitled to substantial deference.'" *Martin v. Occupational Safety & Health Review Comm'n*, 499 U.S. 144, 150 (1991) (citation omitted). This Court has adhered to this principle in a recent case under Title III of the ADA. In concluding that a person with HIV is covered by the Act, the Court relied on Department of Justice regulations, holding that "[a]s the agency directed by Congress to issue implementing regulations . . . the Department's views are entitled to deference." *Bragdon v. Abbott*, 118 S. Ct. 2196, 2209 (1998).<sup>11</sup>

In short, Title II and its implementing regulations compelled the result below, and there is no relevant conflict in the circuits.

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<sup>11</sup> Petitioners attempt to denigrate the Department of Justice's interpretation expressed in an amicus brief to the Eleventh Circuit by characterizing it as a mere "litigation position" not entitled to deference. This Court, however, has held otherwise. In *Auer v. Robbins*, 117 S. Ct. 905 (1997), this Court held that the Department of Labor's interpretation of its regulations issued under the Fair Labor Standards Act was entitled to customary deference despite the fact that its position was first asserted in an amicus brief because "[t]here [was] no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question." 117 S. Ct. at 912. The Department of Justice is in exactly the same position in this litigation, and its interpretation is thus entitled to deference. Moreover, its position was not simply adopted in litigation. The preamble to the integration regulation is equally definitive.

**III. Even If It Had Been Properly Asserted Below, Petitioners' Constitutional Claim Would Not Be Certworthy.**

**A. In This Case, Any Opinion as to the ADA's Validity Under Section Five of the Fourteenth Amendment Would Merely Be Advisory.**

Petitioners contend that the ADA's proscription of unnecessary segregation of the mentally disabled exceeds Congress's authority under section five of the Fourteenth Amendment. In making this argument, Petitioners make the implicit, but mistaken, assumption that if the ADA were declared to be an invalid exercise of Congress's section five power, the judgment rendered below would be reversible for that reason. In passing the ADA, however, Congress not only invoked its power to enforce the provisions of the Fourteenth Amendment, but also expressly relied on its power to regulate interstate commerce. See 42 U.S.C. § 12101(b)(4) (1995) ("It is the purpose of this chapter . . . to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities."). To hold that Congress exceeded its constitutional authority in enacting the ADA, it would be necessary for this Court to find that Congress exceeded *both* its power to enforce the provisions of the Fourteenth Amendment and its power to regulate interstate commerce. *Cf. Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 250-51 (1964) (declining to consider whether Title II of the Civil Rights Act of 1964 might also be a valid enactment under Congress's Fourteenth Amendment enforcement powers, because the Act was found to be a sustainable exercise of Congress's power to regulate interstate commerce). A decision as to the ADA's validity under section five would,

consequently, merely be advisory and would have no impact on the decision below.

**B. In Any Event, Every Court of Appeals To Consider the Issue Has Held That the ADA Does Not Exceed Congress's Power To Enforce the Fourteenth Amendment.**

Petitioners' reliance on the Court's opinion in *City of Boerne v. Flores*, 117 S. Ct. 2157 (1997), to support their contention that the ADA exceeds Congress's power to enforce the Fourteenth Amendment is misplaced. *Flores* involved a challenge to the Religious Freedom Restoration Act (RFRA), a statute which purported to overrule the Court's decision in *Employment Division, Department of Human Resources v. Smith*, 494 U.S. 872 (1990), by legislatively imposing a requirement that any law burdening religion be justified by a compelling government interest and be the least restrictive means of furthering that compelling governmental interest. See *Flores*, 117 S. Ct. at 2160-62. The Court found that those requirements went beyond "[t]he remedial and preventive nature of Congress' enforcement power," *id.* at 2166, by "attempt[ing] a substantive change in constitutional protections," *id.* at 2170. As stated by the Court:

While the line between measures that remedy or prevent unconstitutional actions and measures that make a substantive change in the governing law is not easy to discern, and Congress must have wide latitude in determining where it lies, the distinction exists and must be observed. There must be a congruence and proportionality between the injury to be prevented or remedied and the means adopted to that end. Lacking such a



connection, legislation may become substantive in operation and effect.

*Id.* at 2159.

Both before and after *Flores*, several of the Courts of Appeals have been faced with similar challenges to Congress's exercise of its enforcement power to enact the ADA, and each of them (including four courts after *Flores* was decided) has ruled that the ADA does in fact represent a constitutional exercise of the enforcement power.<sup>12</sup> See *Alsbrook v. City of Maumelle*, 1998 U.S. App. LEXIS 22112 (8th Cir. Sept. 11,

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<sup>12</sup> Each of these cases considered the question whether Congress had exceeded its powers under section five in the context of a challenge to the ADA's abrogation of sovereign immunity. See *Seminole Tribe v. Florida*, 517 U.S. 44, 60-73 (1996) (Congress may not abrogate a state's Eleventh Amendment immunity pursuant to its Article I power to regulate interstate commerce, but only pursuant to its power to enforce the Fourteenth Amendment). No Eleventh Amendment concern stands in opposition to congressional powers here, however. Petitioners have not claimed — and could not claim — Eleventh Amendment immunity in this case. The only defendants in this lawsuit are state officials, and the only relief sought is declaratory and injunctive. This case thus falls within the doctrine of *Ex Parte Young*. See *Green v. Mansour*, 474 U.S. 64, 68 (1985) ("Eleventh Amendment does not prevent federal courts from granting prospective injunctive relief to prevent a continuing violation of federal law."); see, e.g., *Armstrong v. Wilson*, 124 F.3d 1019, 1025-26 (9th Cir. 1997) (holding that "the exception to Eleventh Amendment immunity set forth in *Ex parte Young*, . . . squarely applies to allow this action [brought under the ADA and the Rehabilitation Act of 1973, 29 U.S.C. § 794] against named individuals in their official capacity"). Respondents, therefore, could have proceeded with this suit against Petitioners consistent with the Eleventh Amendment, even if the ADA was validly enacted only with respect to Congress's power to regulate interstate commerce.

1998);<sup>13</sup> *Kimel v. Florida Bd. of Regents*, 139 F.3d 1426, 1433 (11th Cir. 1998); *Coolbaugh v. Louisiana*, 136 F.3d 430, 433-38 (5th Cir.) cert. denied, 67 U.S.L.W. 3230 (Oct. 5, 1998) (No. 97-1941); *Clark v. California Dep't of Corrections*, 123 F.3d 1267, 1270-71 (9th Cir. 1997), cert. denied, 118 S. Ct. 2340 (1998); see also *Crawford v. Indiana Dep't of Corrections*, 115 F.3d 481, 487 (7th Cir. 1997) (pre-*Flores*).

Petitioners' suggestion that the ADA exceeds Congress's enforcement power because the disabled are not a suspect class has been consistently rejected by those decisions. See, e.g., *Clark*, 123 F.3d at 1270-71 ("We reject California's argument that Congress's power must be limited to the protection of those classes found by the Court to deserve 'special protection' under the Constitution."). In the very case that decided that the mentally retarded were not a suspect class, *City of Cleburne v. Cleburne Living Ctr. Inc.*, 473 U.S. 432 (1985), this Court demonstrated that the mentally retarded (like all non-suspect classes) still possess substantial rights under the Equal Protection Clause. In that case, the Court declared invalid under the Equal Protection Clause a requirement that a special-use permit be obtained for a group home for the mentally retarded because the requirement "rest[ed] on an irrational prejudice against the mentally retarded," *id.* at 450, and was, thus, not "rationally related to a legitimate governmental purpose," *id.* at 446. Classifications on the basis of disability are thus a valid subject for congressional legislation pursuant

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<sup>13</sup> Prior to its decision in *Alsbrook v. City of Maumelle*, the Eighth Circuit had come to the same conclusion in *Autio v. AFSCME, Local 3139*, 140 F.3d 802 (8th Cir. 1998). The panel's opinion, however, was vacated by the court's order granting rehearing en banc. Subsequently, by an equally divided vote, the en banc court affirmed without opinion the district court's judgment (the result also reached by the prior panel). 1998 U.S. App. LEXIS 24907 (8th Cir. Oct. 5, 1998).

to Congress's powers under the enforcement clause, just as classifications on the basis of race and gender can be. As stated by Judge Posner on behalf of the Seventh Circuit:

Although the state argues that the ADA is outside the scope of section 5, that argument is refuted by our earlier discussion of Congress's concern that disabled persons are victims of discrimination. Invidious discrimination by governmental agencies, such as Indiana's prison system, violates the equal protection clause even if the discrimination is not racial, though racial discrimination was the original focus of the clause.

*Crawford*, 115 F.3d at 487.

Also misplaced is Petitioners' attempt to analogize the ADA to RFRA, by suggesting that the ADA has impermissibly enacted a more stringent standard of review applicable to equal protection claims by the disabled than that established by this Court in *Cleburne*. In support of this contention, the Petition cites the ADA section enumerating Congress's factual findings, which concludes in pertinent part that the disabled "are a discrete and insular minority" who have been subjected to a history of intentional discrimination. 42 U.S.C. § 12101(a)(7) (1994). While Petitioners are correct that this language "echoes" footnote 4 of *United States v. Carolene Products Co.*, 304 U.S. 144 (1938), Petitioners point to absolutely no indication in the statute itself or in its legislative history that, simply by making this legislative finding, Congress intended to overrule the Court's opinion in *Cleburne*. Nor do Petitioners suggest that the Eleventh Circuit in its opinion below considered the ADA to create a new standard of judicial review for constitutional challenges to agency action. Indeed, as noted by the Third Circuit, "the limited case law is

to the contrary," *Contractors Ass'n v. City of Philadelphia*, 6 F.3d 990, 1001 (3d Cir. 1993) (citing *More v. Farrier*, 984 F.2d 269, 271 n.4 (8th Cir. 1993)), and in the eight years since the ADA was enacted, both this Court and the Courts of Appeals have consistently continued to cite *Cleburne* for the proposition that the mentally retarded and other disabled persons are not a suspect class. See, e.g., *Heller v. Doe*, 509 U.S. 312, 321 (1993);<sup>14</sup> *Kimel*, 139 F.3d at 1441 (Hatchett, C.J., concurring); *id.* at 1449 (Cox, J., dissenting); *Coolbaugh*, 136 F.3d at 433-34 & n.1 (citing five post-ADA Court of Appeals cases in accord with *Cleburne* that the disabled are not a suspect class).

While Congress's legislative finding that the disabled have suffered a history of intentional discrimination may well be persuasive to this Court if it were ever to reconsider its decision in *Cleburne*, Congress did not itself purport to perform that reconsideration for the Court as it did in the context of RFRA. As the Fifth Circuit recently stated:

In the ADA, Congress included no language attempting to upset the balance of powers and usurp the Court's function of establishing a standard of review by establishing a standard different from the one previously established by the Supreme Court. Congress performed one of its traditional legislative functions by finding facts relating to proposed legislation. The Supreme Court may in the future, if it chooses to do so,

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<sup>14</sup> The Petitioner in *Heller v. Doe* argued that the Court should overrule its prior decision in *Cleburne*, based in part on the passage of the ADA. See *Heller*, 509 U.S. at 335 n.1 (Souter, J., dissenting) (describing the Petitioner's argument). However, the Court refused to consider the argument because it was not properly presented below. 509 U.S. at 319.



reconsider the *Cleburne* standard of review in light of the Congressional findings. However, this conflict is not a sufficient reason for us to invalidate the ADA.

*Coolbaugh*, 136 F.3d at 438.

Finally, Petitioners' argument that it is beyond Congress's power to authorize a judicial finding that unnecessary institutionalization is discriminatory on the facts of a particular case, has no merit. As noted above, all of the Courts of Appeals to decide the issue have agreed that, in crafting the ADA, Congress did not cross the line from remedying and preventing constitutional violations to declaring the substance of constitutional rights. Those courts have instead concluded that the ADA demonstrates the "congruence and proportionality between the injury to be prevented or remedied and the means adopted to that end," as specified by this Court in *Flores*. 117 S. Ct. at 2164; *see, e.g., Coolbaugh*, 136 F.3d at 437 (ADA "is not so draconian or overly sweeping to be considered disproportionate to the serious threat of discrimination Congress perceived"); *Clark*, 123 F.3d at 1270 (neither ADA nor Rehabilitation Act "provides remedies so sweeping that they exceed the harms that they are designed to redress").

The ADA's legislative record, backed by detailed Congressional findings regarding the history of discrimination and segregation faced by the disabled, *see* 42 U.S.C. § 12101(a), amply support the conclusion that, at the time of the ADA's passage, there remained "a significant likelihood of unconstitutional actions and therefore a significant 'evil' to be addressed." *Coolbaugh*, 136 F.3d at 437 (describing the "wide range of evidence," including "seven substantive studies or reports" and a "wealth of testimonial and anecdotal evidence

from a spectrum of parties to support the finding of serious and pervasive discrimination"); *Alsbrook*, 1998 U.S. App. LEXIS 22112, at \*10 (noting Congress's "detailed and specific findings regarding the nature and extent of persistent discrimination suffered by individuals with disabilities"). Indeed, as discussed by the Eleventh Circuit, those legislative findings included findings with respect to the very discrimination practiced by the State in this case:

In enacting the ADA, Congress determined that discrimination against individuals with disabilities persists in a wide variety of areas of social life, including "institutionalization," 42 U.S.C. § 12101(a)(3) (1995), and that "individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion . . . [and] segregation . . . ." 42 U.S.C. § 12101(a)(5).

*L.C.*, 138 F.3d at 898. The court also noted Congress's finding that: "Historically, society has tended to isolate and segregate individuals with disabilities, and . . . such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." *Id.* (quoting 42 U.S.C. § 12101(a)(2)). In this important respect, the legislative record of the ADA differs from that of RFRA, which as *Flores* emphasized, "lack[ed] examples of modern instances of generally applicable laws passed because of religious bigotry." 117 S. Ct. at 2169; *see Coolbaugh*, 136 F.3d at 438 (emphasizing the distinction); *Alsbrook*, 1998 U.S. App. LEXIS 22122, at \*10-11.

The specific holding of the courts in this case — that the ADA precludes a state from "confin[ing] an individual with a disability in an institutionalized setting when a community

placement is appropriate," as determined by the "disabled individual's treating professionals," *L.C.*, 138 F.3d at 897, 902 — also demonstrates a congruence and proportionality between the injury to be prevented and the means adopted to that end. Contrary to the State's insistence that the courts created a "per se" right to treatment in a community setting, the Eleventh Circuit explicitly limited its holding to cases where a mentally disabled person is "unnecessarily segregated," *id.* at 899, that is, where "all the experts agree that, at a given time, the patient could be treated in a more integrated setting," *id.* at 903. In addition, the court noted a further limitation inherent in the ADA that the State "need not provide these services if to do so would require a fundamental alteration in its programs," and the court remanded to the district court for further consideration of this issue. *Id.* at 904. Far from "disturb[ing] the delicate balance between the national government and the State governments," (Pet. at 15-16), as asserted in the Petition, the ADA, as applied by the Eleventh Circuit in this case, presents a measured response to an intractable example of unnecessary segregation, which expressly takes into account the State's concerns in maintaining the fundamental integrity of its programs.

### CONCLUSION

The Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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October 28, 1998



## **APPENDIX**

28 C.F.R. § 41.51(d) (1998):

Recipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.



Excerpt from page 34 of Petitioners' Brief to the Eleventh Circuit Court of Appeals:

In light of the active litigation on this issue, it seems reasonable that if Congress believed the courts were incorrect in interpreting its intent on the issue of deinstitutionalization and had wished to clarify it, it would have surely done so when it passed the ADA. Yet neither the explicit language of the ADA nor the legislative history call for or require deinstitutionalization of mentally retarded individuals. If Congress had intended such a radical step, it surely would have clearly stated it. Radical it would have been, because a statute requiring deinstitutionalization on this basis not only would have severe practical effects but also would clearly exceed the congressional power to enforce either the Commerce Clause or the Fourteenth Amendment. See Printz v. United States, 1997 WL 351180 (U.S.) (Brady Act not enforceable under Necessary and Proper Clause); City of Boerne v. Flores, 1997 WL 345322 (U.S.) (Religious Freedom Restoration Act not enforceable under Section 5 of the Fourteenth Amendment).

4

No. 98-536

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SUPREME COURT, U.S.

In The  
**Supreme Court of the United States**  
October Term, 1998

TOMMY OLMSTEAD, Commissioner of the Department  
of Human Resources of the State of Georgia, RONALD C.  
HOGAN, Superintendent of Georgia Regional Hospital/  
Atlanta, and EARNESTINE PITTMAN, Executive  
Director of the Fulton County Regional Board,

*Petitioners,*

v.

L.C. and E.W., each by JONATHAN ZIMRING,  
as guardian ad litem and next friend,

*Respondents.*

On Petition For A Writ Of Certiorari  
To The United States Court Of Appeals  
For The Eleventh Circuit

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12/2/98



## TABLE OF CONTENTS

|   | Page |
|---|------|
| I. The Eleventh Circuit's Decision Is Important ...   | 1    |
| II. The Patients' Procedural Arguments Should Be Rejected. ....                               | 2    |
| III. The Patients' Argument That There Is No Conflict Among the Circuits Is Without Merit ... | 4    |
| IV. The Constitutional Question Merits Review ..  | 5    |

## TABLE OF AUTHORITIES

## Page

## CASES:

|   |      |
|---|------|
| <i>Batson v. Kentucky</i> , 476 U.S. 79 (1986) .....  | 4    |
| <i>Bragdon v. Abbott</i> , ___ U.S. ___, 118 S.Ct. 2196, 141<br>L.Ed.2d 540 (1998).....   | 4    |
| <i>Carlson v. Green</i> , 446 U.S. 14 (1980).....   | 2, 4 |
| <i>City of Boerne v. Flores</i> , 521 U.S. ___, 117 S.Ct. 2157,<br>138 L.Ed.2d 624 (1997).....  | 5, 6 |
| <i>Edelman v. Jordan</i> , 415 U.S. 651 (1974) .....  | 6    |
| <i>Erie R.R. v. Tompkins</i> , 304 U.S. 64 (1938).....  | 4    |
| <i>Ex parte Young</i> , 209 U.S. 123 (1908).....  | 6    |
| <i>Freytag v. Commissioner</i> , 501 U.S. 868 (1991) .....  | 3    |
| <i>Garcia v. San Antonio Metropolitan Transit Auth.</i> ,<br>469 U.S. 528 (1985) .....  | 7    |
| <i>Green v. Mansour</i> , 474 U.S. 64 (1985) .....  | 6    |
| <i>Helen L. v. DiDario</i> , 46 F. 3d 325 (3d Cir. 1995), <i>cert.</i><br><i>denied</i> , 516 U.S. 813 (1995).....                            | 1, 5 |
| <i>Kathleen S. v. Dept. of Public Welfare of Penn.</i> , 1998<br>U.S. Dist. LEXIS 11819 (E.D.Pa. 1998) ( <i>unre-</i><br><i>ported</i> )..... | 1, 2 |
| <i>New York v. United States</i> , 505 U.S. 144 (1992) .....  | 7    |
| <i>Printz v. United States</i> , ___ U.S. ___, 117 S.Ct. 2365,<br>138 L.Ed.2d 914 (1997).....   | 7    |
| <i>Seminole Tribe of Florida v. Florida</i> , 517 U.S. 44<br>(1996) .....   | 6    |

## TABLE OF AUTHORITIES - Continued

## Page

|   |      |
|---|------|
| <i>The Conqueror</i> , 166 U.S. 110 (1897).....                             | 2    |
| <i>United States v. General Motors Corp.</i> , 323 U.S. 373<br>(1945) ..... | 2, 3 |
| OTHER:  |      |
| H.R.Rep. No. 101-485(III), 101st Cong., 2d Sess. 84<br>(1990) .....         | 4    |
| 56 Fed.Reg. 33,694 (1991) .....   | 4    |



## REPLY BRIEF OF PETITIONERS

### I. The Eleventh Circuit's Decision Is Important.

The main point in the patients' responsive brief seems to be that this case really is not so important after all. For example, their very first argument is that the patients "did not claim as stated by Petitioners" that the Americans With Disabilities Act (ADA) required the provision of community-based treatment. (Resp. Brief, p. 1). Yet the patients sought and obtained an injunction under the ADA for exactly that result – community-based treatment. By the patients' own estimates, these placements cost over \$70,000 annually for each patient. (See Plaintiffs' Brief On Remand, Ex. 2). Their argument that they did not claim they were entitled to this under the ADA defies logic.

Similarly, they also argue that the State officials "repeatedly misstate the court's holding as a finding that institutionalization constitutes 'discrimination *per se*' . . . and assert without basis that the decision grants a '*per se* right to community placement.' " (Resp. Brief, p. 4). In spite of the patients' attempt to understate the importance of this opinion, however, the record shows that the Eleventh Circuit's interpretation of the "integration mandate" is being wielded as a weapon throughout the country, both by patients and by the Department of Justice, to force deinstitutionalization. For example, one district court has ordered the discharge of as many as 256 patients from institutions to community placements, relying on this case and on *Helen L. v. DiDario*, 46 F. 3d 325 (3d Cir. 1995), *cert. denied*, 516 U.S. 813 (1995). *Kathleen S. v. Dept. of Public Welfare of Penn.*, 1998 U.S. Dist. LEXIS

11819, \*1,\*7 (E.D.Pa. 1998) (unreported). The Justice Department also is attempting to enforce the interpretation of the Eleventh Circuit as a *requirement on all states*. (Amicus Brief of the States of Florida, *et al.*, pp. 7, 1a to 27a). This requirement would apply not only in the delivery of services to mentally ill and mentally retarded persons, but also in connection with services in nursing homes.

The Eleventh Circuit's interpretation thus dramatically impacts not only Petitioners but all of the states. It has caused confusion about the validity of the State's entire services-delivery system, and it has created uncertainty about the continued viability of the State's institutions. The budgetary impact could be enormous. This Court should step in now and provide guidance on this important issue.

## II. The Patients' Procedural Arguments Should Be Rejected.

The Respondents make two procedural arguments against the Court's considering this case. The Court should reject both arguments, concluding instead "that the interests of judicial administration will be served by addressing the issue on its merits." *Carlson v. Green*, 446 U.S. 14, 17 n. 2 (1980).

The patients first argue that review should be denied on the ground that the court of appeals' judgment is not final. Both the pertinent statute and this Court's cases, however, permit review of nonfinal judgments or proceedings. 28 U.S.C. § 1254(1) (1994); *The Conqueror*, 166 U.S. 110, 113-14 (1897); *see, e.g., United States v. General*

*Motors Corp.*, 323 U.S. 373, 377 (1945) (review granted for case remanded by court of appeals for trial).

In the present case, the court of appeals affirmed the district court's judgment, and yet it also remanded the case for further proceedings. In practical effect, the court of appeals' decision is final, because it finally construes the ADA and the integration regulation. The only job left on remand is for the district court to adduce evidence on the fundamental-alteration issue. Nothing that the district court can do now will obviate, correct, or alter the legal error already committed by the court of appeals. This case is ripe for review.

The patients' second procedural argument is that one of the questions presented (the constitutional issue) was not raised adequately below. Initially, the State officials argued in the district court that the patients' position was clearly erroneous as a matter of statutory construction. Only when the district court agreed with the patients on the statute's meaning did the constitutional issue actually arise. That issue is whether, if the district court's construction of the statute is right, the statute violates the Constitution.

The State officials did raise this issue expressly in their briefs in the court of appeals, as the patients acknowledge. (Resp. Brief, pp. 6, A-2). The court of appeals certainly could have addressed that issue if it had wanted to do so, once it approved the district court's construction of the statute. In any event, this Court is not precluded from deciding issues that were not presented below. *See, e.g., Freytag v. Commissioner*, 501 U.S. 868



(1991); *Batson v. Kentucky*, 476 U.S. 79, 112-18 (1986); *Carlson, supra*; *Erie R.R. v. Tompkins*, 304 U.S. 64, 80-82 (1938). This issue is of sufficient importance to warrant review by this Court. Further, even if the Court declines review of the constitutional issue, the statutory issue alone should be reviewed.

### III. The Patients' Argument That There Is No Conflict Among the Circuits Is Without Merit.

The patients' argument that there is no conflict among the circuits relies on their assertion that cases decided under the Rehabilitation Act are irrelevant to a claim under the ADA. (Resp. Brief, p. 8). This argument is easily answered.

This Court relied extensively on interpretations of § 504 of the Rehabilitation Act in a recent decision on the ADA. *Bragdon v. Abbott*, \_\_\_ U.S. \_\_\_, 118 S.Ct. 2196, 141 L.Ed.2d 540 (1998). Far from being irrelevant, the Court found that prior administrative and judicial interpretations of § 504 actually settled the meaning of the ADA. 118 S.Ct. at 2207-08, 141 L.Ed.2d at 559-562 (1998).

Further, the legislative history and administrative comments regarding Title II of the ADA repeatedly state that it closely followed § 504. *See, e.g.*, H.R.Rep. No. 101-485(III), 101st Cong., 2d Sess. 84 (1990) ("The Committee intends that title II work in the same manner as § 504"); 56 Fed.Reg. 33,694 (1991) ("Because Title II of the ADA essentially extends the nondiscrimination mandate of § 504 to those state and local governments that do not receive federal financial assistance, this rule hews closely

to the provisions of existing § 504 regulations"). The courts have uniformly applied cases on § 504 to the ADA. *See, e.g., Helen L., supra*, 46 F.3d at 330 n. 7 ("The law developed under § 504 of the Rehabilitation Act is applicable to Title II of the ADA"). For the patients to state that this law is "irrelevant" is without merit.

Additionally, the patients argue that the regulation was "simply applied" to the undisputed facts. (Resp. Brief, p. 11). They cite to isolated comments by the Attorney General and also to another version of the integration mandate<sup>1</sup> in support of this argument. Yet neither these comments nor the regulation even suggest, much less state plainly, that the integration mandate applies to services and programs that are provided *only* to individuals with disabilities.

### IV. The Constitutional Question Merits Review

Finally, the patients have asserted that the constitutional question is not worthy of review. Two quick rejoinders apply here. First, even if the constitutional issue were not substantial, the statutory issue alone deserves review. Also, the patients' devoting more than half of their responsive argument to the constitutional issue belies their assertion that the issue is unimportant.

The bulk of the patients' constitutional argument is an attempt to distinguish the present case from *City of Boerne v. Flores*, 521 U.S. \_\_\_, \_\_\_, 117 S.Ct. 2157, 2159, 138

<sup>1</sup> The version of the integration mandate cited by the patients is not the one that was construed by the Eleventh Circuit. *See Pet.*, 4a *et seq.*

L.Ed.2d 624, 638 (1997). *Flores* points out that, under Section 5 of the Fourteenth Amendment, "the line between measures that remedy or prevent unconstitutional actions and measures that make a substantive change in the governing law is not easy to discern." The only reply necessary now is that the patients' argument not only fails to persuade on the merits but also, by its vigor, strongly supports the State officials' position that the constitutional question is a substantial one.

Another branch of the patients' constitutional argument is that the Commerce Clause can provide support if the Fourteenth Amendment fails as a foundation for Title II, the public-entities part of the ADA. The Clause cannot serve that function, however. First, the Eleventh Amendment bars all suits for damages against the States based on the Clause. *Seminole Tribe of Florida v. Florida*, 517 U.S. 44, 55-73 (1996). That the present suit seeks injunctive relief and pends against State officials rather than against the State itself does not change that rule here. The well-known exception under *Ex parte Young*, 209 U.S. 123 (1908), which authorized certain injunctive suits against state officials, does not permit suits for injunctions where the violations are not continuing and where state funds are to be used for redress of past wrongs. *Green v. Mansour*, 474 U.S. 64 (1985); *Edelman v. Jordan*, 415 U.S. 651 (1974). In the present case, the patients sought State-paid community placements – placements that the State provided and continues to provide.

Not only the Eleventh Amendment but also the Tenth Amendment may prevent the Commerce Clause from serving as a basis for Title II of the ADA. Of course, the

federal government may enforce, against the states, commercial regulations that are equally applicable to governmental and nongovernmental activities. *Garcia v. San Antonio Metropolitan Transit Auth.*, 469 U.S. 528 (1985). Title II, however, applies expressly only to public entities, and it is sought to be enforced here by suit against State officials. In *New York v. United States*, 505 U.S. 144 (1992), this Court held that the Commerce Clause, being limited by the Tenth Amendment, provides no basis for Congress to order State governments to enact specific legislation or to take title to private property. In *Printz v. United States*, \_\_\_ U.S. \_\_\_, 117 S.Ct. 2365, 138 L.Ed.2d 914 (1997), this Court held that, in light of the Amendment and other parts of the Constitution, the Clause does not permit Congress to require State or local executive officers to implement federal law. Thus, the Tenth Amendment may well bar the Commerce Clause's use as a foundation for Title II of the ADA.

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**OCTOBER TERM, 1998**

**TOMMY OLMSTEAD, Commissioner of the Department  
of Human Resources of the State of Georgia, et al.,**

**Petitioners,**

**vs.**

**L.C. and E.W., each by JONATHAN ZIMRING,  
as guardian ad litem and next friend,**

**Respondents.**

**On Petition For A Writ Of Certiorari  
To The United States Court of Appeals  
For The Eleventh Circuit**

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52 PW



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## **TABLE OF CONTENTS**

|   |    |
|---|----|
| List of Parties Joining in Brief .....  | i  |
| Table of Contents .....   | iv |
| Table of Citations and Authorities .....  | vi |
| Interest of Amici .....   | 1  |
| Summary of Argument .....   | 1  |
| Argument .....  | 2  |
| I. THE PETITION PRESENTS IMPORTANT<br>QUESTIONS OF FEDERAL LAW THAT<br>SHOULD BE DECIDED BY THIS COURT ....   | 2  |
| A. The impact on the states' delivery of<br>services to individuals with disabilities .....   | 2  |
| B. This Court is not bound by the<br>DOJ's current interpretation of<br>the Integration Rule, 28 C.F.R.<br>§35.130(d) .....   | 8  |
| i. The DOJ's current interpretation<br>of the Integration Rule differs<br>from the interpretation which was<br>in place and followed prior to the<br>enactment of the ADA ..... | 8  |
| ii. DOJ's administrative interpretation<br>of the ADA, as embodied in the<br>Integration Rule, is erroneous .....   | 13 |

|  |    |
|--|----|
| C. Alternatively, the statute violates the Tenth and Eleventh Amendments to the United States Constitution . . . . . | 17 |
| Conclusion . . . . .   | 20 |

## TABLE OF AUTHORITIES

### FEDERAL CASES

|   |        |
|---|--------|
| <u>Alexander v. Choate</u> , 469 U.S. 287,<br>105 S. Ct. 712, 83 L. Ed. 2d 661 (1985) . . . . .   | 16     |
| <u>Amos v. Maryland Department of Public<br/>Safety and Correctional Services</u> ,<br>126 F.3d 589 (4th Cir. 1997) . . . . .                           | 18     |
| <u>Bowen v. American Hospital Association</u> ,<br>476 U.S. 610, 106 S. Ct. 2101 (1986) . . . . .   | 16     |
| <u>Bragdon v. Abbott</u> , ___ U.S. ___,<br>118 S. Ct. 2196, 141 L. Ed. 2d 540 (1998) . . . . .   | 9, 12  |
| <u>City of Boerne v. Flores</u> , ___ U.S. ___,<br>117 S. Ct. 2157, 138 L. Ed. 2d 624 (1997) . . . . .  | 18, 19 |
| <u>Civil Rights Cases</u> , 109 U.S. 3, 3 S. Ct. 18,<br>27 L. Ed. 835 (1883) . . . . .  | 19     |
| <u>Clark v. Cohen</u> , 794 F.2d 79 (3d Cir. 1986) . . . . .  | 11     |
| <u>Conner v. Branstad</u> , 839 F. Supp. 1346<br>(S.D.Iowa 1993) . . . . .  | 12     |
| <u>Garrity v. Gallen</u> , 522 F. Supp. 171<br>(D.N.H. 1981), affirmed sub nom.<br><u>Garrity v. Sununu</u> , 752 F.2d 727<br>(1st Cir. 1984) . . . . . | 12     |



|  |                  |
|--|------------------|
| <u>Helen L. v. DiDario</u> , 46 F.3d 325<br>(3d Cir. 1995), cert. den. sub nom.<br><u>Pennsylvania Secretary of Public<br/>Welfare v. Idell S.</u> , 516 U.S. 813,<br>116 S. Ct. 64, 133 L. Ed. 2d 26 (1995) ..... | 7, 9             |
| <u>L. C. by Zimring v. Olmstead</u> ,<br>138 F.3d 893 (11th Cir. 1998) .....   | <i>en passim</i> |
| <u>Lincoln CERCPAC v. Health and<br/>Hospitals Corp.</u> , 147 F.3d 165 (2nd Cir. 1998) .....  | 17               |
| <u>National Credit Union Admin. v. First National<br/>Bank &amp; Trust Co.</u> , ___ U.S. ___,<br>118 S. Ct. 927 (1998) .....  | 13               |
| <u>Oberti v. Board of Education</u> ,<br>995 F.2d 1204 (3d Cir. 1993) .....  | 16               |
| <u>Phillips v. Thompson</u> , 715 F.2d 365<br>(7th Cir. 1983) .....  | 12               |
| <u>Southeastern Community College v. Davis</u> ,<br>442 U.S. 397, 99 S. Ct. 2361,<br>60 L. Ed. 2d 980 (1979) .....   | 16               |
| <u>Traynor v. Turnage</u> , 485 U.S. 535,<br>108 S. Ct. 1372, 99 L. Ed. 2d 618 (1988) .....  | 16               |
| <u>Ex Parte Virginia</u> , 100 U.S. 339,<br>25 L. Ed. 2d 676 (1879) .....  | 18               |
| <u>Williams v. Wasserman</u> ,<br>937 F. Supp. 524 (D.Md. 1996) .....  | 4                |
| <u>Youngberg v. Romeo</u> , 102 S. Ct. 2452,   |                  |

|  |    |
|--|----|
| 457 U.S. 307, 73 L. Ed. 2d 28 (1982) ..... | 19 |
|--|----|

## FEDERAL STATUTES

|                                 |                  |
|---------------------------------|------------------|
| 29 U.S.C. §794 .....            | <i>en passim</i> |
| 42 U.S.C. §6042 et seq. ....    | 4                |
| 42 U.S.C. §§12101 et seq .....  | <i>en passim</i> |
| 42 U.S.C. §12101(a)(2) .....    | 13               |
| 42 U.S.C. §12101(a) (3) .....   | 13               |
| 42 U.S.C. §12101(a) (5) .....   | 13               |
| 42 U.S.C. §12101(b)(4) .....    | 18               |
| 42 U.S.C. §12132 .....          | 1                |
| 42 U.S.C. §12182(b)(1)(B) ..... | 16               |
| 42 U.S.C. §12181(7) .....       | 16               |

## FEDERAL REGULATIONS

|                                   |      |
|-----------------------------------|------|
| 28 C.F.R. §35.105(a) .....        | 6    |
| 28 C.F.R. § 35.130 .....          | 17   |
| 28 C.F.R. §35.130(b)(1)(iv) ..... | 9    |
| 28 C.F.R. §35.130(d) .....        | 1, 8 |
| 28 C.F.R. §39.130(d) .....        | 10   |

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|   |       |
|---|-------|
| 135 Cong. Rec. S10897 (9/7/89) .....                                | 15    |
| 49 Fed. Reg. 35,724, at 35,728 .....                                | 11    |
| 56 Fed. Reg. 35,694, 35,703 .....                                   | 9, 11 |
| H.R. Rep. No. 101-485(II),<br>101st Cong., 2d Sess. 84 (1990) ..... | 17    |
| U.S. Code Cong. & Admin. News 1990<br>pp. 267, 303, 366-367 .....   | 17    |

## INTEREST OF AMICI

Amici are all states and a territory which provide various services and programs for treatment and habilitation of individuals with disabilities. The decision of the Eleventh Circuit in L.C. by Zimring v. Olmstead, 138 F.3d 893 (11th Cir. 1998), dramatically impacts Amici in many ways. The opinion has been relied upon in several lawsuits designed to reshape the manner in which services (*not provided to nondisabled persons*) are provided by the states to individuals with disabilities. Also, the opinion has created uncertainty on the part of the states as to the continued viability of institutionalized care of individuals with disabilities. In an environment of limited fiscal resources, the states require a prompt determination by this Court as to whether Title II of the Americans with Disabilities Act, Title 42 U.S.C. §12132 (ADA), and the Integration Rule<sup>1</sup> require the delivery of "disability services" (i.e., services that are provided for habilitation and treatment of disabilities and *are not available to nondisabled persons*) in the most integrated community setting available.

## SUMMARY OF ARGUMENT

In L.C. by Zimring, 138 F.3d, at 902, the Eleventh Circuit held "that where . . . a disabled individual's treating professionals find that a community-based placement is appropriate for the individual, the ADA imposes a duty to provide treatment in a community setting--the most integrated setting appropriate to that patient's needs." In reaching this conclusion, the Eleventh Circuit relied upon an interpretation of the Integration Rule which *first appeared in 1994*, several years after the ADA was enacted. This

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<sup>1</sup>/This rule provision is also referred to as the Integration Mandate, 28 C.F.R. §35.130(d).



1994 interpretation was accorded undue deference below. Amici strongly contend that the current U. S. Department of Justice (DOJ) interpretation of the Integration rule is neither mandated by the express language of the ADA nor reasonable.

Furthermore, in holding that the ADA required such community-based services, the Eleventh Circuit deviated from the established jurisprudence of this Court that the ADA and its predecessor, the Rehabilitation Act of 1973, Title 29 U.S.C. §794 (§504), were designed to ensure *evenhanded* treatment between individuals with disabilities and nondisabled persons. The effect of the Eleventh Circuit holding is to afford preferential treatment to individuals with disabilities, because it requires the provision of services *available to disabled individuals only* in a community-based setting.

Alternatively, to the extent that the ADA obligates states to provide substantive services to its citizenry in a community-based setting, it violates the Tenth and Eleventh Amendments to the United States Constitution.

## **ARGUMENT**

### **I. THE PETITION PRESENTS IMPORTANT QUESTIONS OF FEDERAL LAW THAT SHOULD BE DECIDED BY THIS COURT.**

#### **A. The impact on the states' delivery of services to individuals with disabilities.**

The impact of the Eleventh Circuit's opinion on the provision of services to individuals with disabilities is quite profound, and

cannot be limited to the delivery of services to mentally ill persons in institutions. In Florida, the Integration Rule (and the construction of that rule applied by the Eleventh Circuit) has been relied upon, in part, in a series of class action lawsuits which address the manner in which services are provided to individuals with developmental disabilities. Those individuals who currently reside in and receive habilitation and treatment from the State of Florida's developmental services institutions<sup>2</sup> (D.S.I.s) argue that the ADA and the Integration Rule require that the D.S.I.s be shut down, and that these individuals be placed in inclusive community-based settings.

Those individuals with developmental disabilities already receiving services in inclusive community settings have also sued the state, asserting that the Integration Rule and the ADA require that they receive more services in order to avoid placement in an institution or a less integrated setting like an Intermediate Care Facility for the Mentally Retarded or a nursing home. In every instance, the services at issue are services that are provided to the plaintiffs because of their developmental disabilities, and are not available to nondisabled persons.

The Integration Rule has also been relied upon in an action seeking to close one of Florida's state mental hospitals. If successful, this action will result in other similar lawsuits. Such litigation will severely impact the remaining state mental hospitals.<sup>3</sup>

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<sup>2</sup>/Developmental Services Institutions are owned and operated by the State of Florida, and house and provide treatment and habilitation for some of Florida's profound and severely developmentally disabled adults. §393.063(12), Fla. Stat. (1997).

<sup>3</sup>/There is a difference of opinion in the mental health field regarding the value

Also, Florida's Protection and Advocacy System (P & A) [see Title 42 U.S.C. §6042 *et seq.*] has been granted leave to intervene in a nursing home receivership action. The P & A is seeking the transfer of all individuals with disabilities who are currently cared for in a failed nursing home to inclusive community-based placements rather than other nursing homes.

Similar lawsuits have been filed in other states. In Williams v. Wasserman, 937 F.Supp. 524, 526 (D.Md. 1996), plaintiffs brought an ADA claim,<sup>4</sup> challenging the alleged failure of Maryland to implement the recommendations of treating professionals and/or the parties' experts to provide community-based rather than institutional care. That case is still pending.

Also, Maryland's P & A has sued to close a facility which provides treatment for individuals with developmental disabilities. Additionally, Maryland's P & A has sued to force the State to care for an elderly mentally ill person in a community placement rather than in a nursing home. Although efforts have been made to locate an appropriate placement for this individual, no such placement has been found to date.

Also, DOJ, pursuant to the Integration Rule, has demanded that Maryland move all of the children with mental retardation currently cared for in one of the State's facilities because of their medical conditions, into community-based placements.

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of deinstitutionalization for a significant percentage of the population receiving treatment for mental illness in institutional settings. See e.g., E. Fuller Torrey, M.D., *Out of the Shadows, Confronting America's Mental Illness Crisis* (1997).

<sup>4</sup>The action also includes a claim under the Due Process Clause.

These are just a few examples of how the Integration Rule is now being used as a blunt and inefficient instrument to restructure the manner in which the states provide services to individuals with disabilities. If applied elsewhere, the Eleventh Circuit's interpretation of the ADA and the Integration Rule will necessarily affect the manner in which services are provided to individuals with disabilities in any group setting. It is self-evident that, if a state expends enough money, virtually any person can safely and appropriately be served in his or her own home (or in the most integrated community setting). However, legitimate fiscal reality limits the ability of the states to adequately fund community-based placements for *all* individuals with disabilities.

Clearly, no state is immune from such challenges. Even for those states that have initiated "deinstitutionalization" efforts, there still exists the threat of litigation regarding group homes, nursing homes, and other settings which are not adequately "home-like" in nature. In those states where institutions still exist, if litigation has not already commenced, it clearly looms on the horizon.

The Eleventh Circuit suggested below that there was a distinction between an action brought by two individuals seeking to be placed in a community-based setting and a class of plaintiffs seeking the same relief. L.C. by Zimring, 138 F.3d, at 904 n. 10. Such a distinction is illusory at best, and invites an onslaught of small lawsuits seeking placement in the most integrated community setting. Whether the relief is sought by a class or by individuals, the cumulative impact on the available state monies for the delivery of services is the same. It is oppressive.

If the institutional populations drop significantly, the facility-based reimbursement schemes in place nationwide will be severely



undermined because of the diseconomies of scale created by the deinstitutionalization.<sup>5</sup> Further, there exist a finite number of community placements that are appropriate for individuals with disabilities. Consequently, the increased demand for additional community placements will require the states to quickly create and fund such placements. Such a scenario, driven by litigation to provide the most integrated community placements, will drive up the costs of providing services to individuals with disabilities in the community as well.

In addition, the states have also been advised that two federal agencies<sup>6</sup> are now requiring that the states address the ADA's integration requirement (as interpreted by the Eleventh Circuit) in the states' "self-evaluations."<sup>7</sup> The integration requirement is to be applied to all state activities, including the provision of nursing home, institutional and community-based services. According to DOJ and HHS, failure to address the ADA's integration requirement in the states' self-evaluations, will cause the self-evaluations to be incomplete. *Id.*

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<sup>5</sup>/See e.g., David Braddock et al., *The State of the States in Developmental Disabilities: Summary of the Study* (5th Ed.), Chapter 2, pg. 27, where the authors noted, that although institutional populations were continuing to decline:

Aggregate staffing of institutions has declined substantially but less rapidly than the residential census. As a result average daily costs have risen substantially . . .

(Emphasis supplied)

<sup>6</sup>/The DOJ and the Department of Health & Human Services (HHS). See Appendix, pp. 1a to 27a.

<sup>7</sup>/Pursuant to 28 C.F.R. §35.105(a), every public entity is required to conduct a self-evaluation of its "current services, policies, and practices, and the effects thereof," to determine whether they meet the requirements of Title II of the ADA.

The broad-ranging impact on the states of the Eleventh Circuit's holding cannot be underestimated, and is particularly problematic because it relies upon a DOJ interpretation of the Integration Rule which is of recent vintage. Historically, as is discussed further below, both the ADA and the Integration Rule were interpreted in light of services, benefits and aids which were available to nondisabled persons, and which, with reasonable modifications, could be provided to individuals with disabilities as well. The ADA (and its predecessor the Rehabilitation Act of 1973) and the Integration Rule were historically construed to prohibit a public entity from offering separate service, aid and benefit programs to individuals with disabilities than were offered to nondisabled persons. Until approximately 1994, the ADA and Integration Rule were not applied to services, aids and benefits which were available exclusively to individuals with disabilities, and which were not provided to nondisabled persons. *Helen L. v. DiDario*, 46 F.3d 325, 331-332 (3d Cir. 1995), *cert. den. sub nom. Pennsylvania Secretary of Public Welfare v. Idell S.*, 516 U.S. 813, 116 S.Ct. 64, 133 L.Ed.2d 26 (1995).

These changes in the interpretation of the ADA and the Integration Rule have created confusion and uncertainty on the part of the states. The states need direction from this Court regarding the reach of these statutes and regulations. The Eleventh Circuit concluded: "Under the ADA, as with other federal statutes, '[i]nadequate state appropriations do not excuse noncompliance with federal law.'" *L.C. by Zimring*, 138 F.3d, at 904. Assuming *arguendo* that this is correct, inadequate state

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<sup>8</sup>/The Eleventh Circuit also noted that the federal government "matches" state dollars for Medicaid funds spent by the State. *Id.* However, even with matching funds, the States are still obligated to pay 45% of the cost of placement - whatever that cost may be.

appropriations for the costs of massive "deinstitutionalization" will not be a defense to any ADA challenge filed against the states.<sup>9</sup>

Since the states need to know with certainty their funding responsibilities under the ADA, and they need to know whether they must provide, in the most integrated community setting, services *which are provided to individuals with disabilities only*, swift consideration by this Court of these issues is imperative. Further, since the Eleventh Circuit's opinion appears to impact a broad variety of services (and not simply the delivery of mental health services to consumers of such services), it is crucial to the states that this Court exercise its discretionary certiorari jurisdiction to review this case.

**B. This Court is not bound by the DOJ's current interpretation of the Integration Rule, 28 C.F.R. §35.130(d).**

**i. The DOJ's current interpretation of the Integration Rule differs from the interpretation which was in place and followed prior to the enactment of the ADA.**

The Eleventh Circuit Court of Appeals' holding is based, in part, on the Integration Rule, 28 C.F.R. §35.130(d), which provides that "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." In concluding that the ADA required provision of community-based placements, the Eleventh Circuit accorded substantial deference to §35.130(d), stating that: "It is well-settled that where 'a Congress that reenacts

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<sup>9</sup>/Although the Eleventh Circuit asserted that its opinion did not mandate deinstitutionalization, L.C., 138 F.3d, 902, the states contend that the practical effect of the opinion below will be mass deinstitutionalization.

a statute voices its approval of an administrative . . . interpretation thereof, Congress is treated as having adopted that interpretation and this Court is bound thereby." L.C. by Zimring, 138 F.3d 893.

In fact, the "administrative interpretation" so heavily relied upon by the Eleventh Circuit postdates the enactment of the ADA, and should not be given the deference afforded it by the Eleventh Circuit.<sup>10</sup> This case is in sharp contrast to Bragdon v. Abbott, \_\_\_ U.S. \_\_\_, 118 S.Ct. 2196, 141 L.Ed.2d 540 (1998). In Bragdon, this Court addressed the issue of whether asymptomatic HIV positive persons were "disabled" for the purposes of an action brought pursuant to the ADA. The Court noted: "Our holding is confirmed by a consistent course of agency interpretation before and after enactment of the ADA. Every agency to consider the issue under the Rehabilitation Act of 1973 found statutory coverage for persons with asymptomatic HIV." Id., 118 S.Ct.2196, 2206. In the case at bar, prior to enactment of the ADA, the Rehabilitation Act and its regulations were consistently interpreted as *not* requiring community-based placements.

Section 35.130(d) must be viewed in conjunction with 28 C.F.R. §35.130(b)(1)(iv),<sup>11</sup> which requires that agencies not "[p]rovide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities *than is provided to others* unless such action is necessary to provide qualified individuals with disabilities with

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<sup>10</sup>/The first circuit court to conclude that the ADA encompassed a requirement that individuals with disabilities be provided with community based placements was the Third Circuit Court of Appeals, in Helen L. v. DiDario, *supra*.

<sup>11</sup>/ 56 Fed. Reg. 35,694, 35,703.



aids, benefits, or services that are as effective *as those provided to others.*" (Emphasis supplied) As discussed below, these two rules, when read together, reflect that the longstanding DOJ interpretation of the ADA was that it afforded relief only in those circumstances where the services and programs at issue were provided to both disabled and nondisabled persons.

The Integration Rule has existed for some time. A similar rule was enacted pursuant to the Rehabilitation Act of 1973, 29 U.S.C. §794, which provided: "The agency shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 C.F.R. §39.130(d). A review of the historical "Section-by-Section Analysis and Response to Comments," which pertain to the predecessor rules to the ADA Integration Rule, suggests that the DOJ previously interpreted the Integration Rule to have a much narrower reach, and limited the application of the regulation to those services, aids or benefits which were provided to both disabled and "other" persons.

In 1984, DOJ's section-by-section analysis regarding the Integration Rule adopted pursuant to the Rehabilitation Act of 1973, 28 C.F.R. §39.130(d), provided:

Despite the mandate of paragraph (d) that the agency administer its programs and activities in the most integrated setting appropriate to the needs of the qualified handicapped persons, subparagraph (b)(1)(iv), in conjunction with paragraph (d), permits the agency to develop separate or different aids, benefits, or services when necessary to provide handicapped persons with an equal opportunity to participate in or benefit from the

agency's programs or activities. Subparagraph (b)(1)(iv) requires that different or separate aids, benefits or services are as effective as *those provided to others.* Even when separate or different aids, benefits, or services would be more effective, subparagraph (b)(2) provides that *a qualified handicapped person still has the right to choose to participate in the program that is not designed to accommodate handicapped persons.* (Emphasis supplied)

49 Fed. Reg. 35,724, at 35,728.

As recently as 1991, DOJ's section-by-section analysis for the Integration regulations enacted by DOJ to implement and interpret the ADA included similar language. 56 Fed. Reg. 35,694, 35,703.

The comments and analysis prepared by DOJ regarding the pertinent regulations implementing the Rehabilitation of 1973, §§39.130(b)(1)(iv) and (d), when read in conjunction with each other, reflect that these rule provisions have historically been designed to address the provision of services to individuals with disabilities, which services are also available to "others" (or nondisabled persons). Similarly, the regulations enacted in 1991 by DOJ relating to the ADA clearly carried over that theme into the new regulatory scheme.

Further, prior to the enactment of the ADA, the courts did not interpret the Rehabilitation Act or the regulations enacted pursuant to that Act to prohibit institutionalization of individuals with disabilities (or to require provision of services in a community-based setting). *Clark v. Cohen*, 794 F.2d 79, 98 (3d Cir. 1986) (Section 504 prohibits discrimination against the handicapped in

federally funded programs, and imposes no affirmative obligations on the states to furnish services); Garrity v. Gallen, 522 F.Supp. 171, 213 (D.N.H. 1981), *affirmed sub nom. Garrity v. Sununu*, 752 F.2d 727, 729 (1st Cir. 1984) ("We agree that § 504 cannot be construed so broadly as to require deinstitutionalization. Nor do we think that the Department of Health and Human Services envisioned such an interpretation of § 504, as evidenced by the provisions of 45 C.F.R. §84.54, dealing with Education of Institutionalized persons."); and Phillips v. Thompson, 715 F.2d 365, (7th Cir. 1983) ("Appellants appear to contend that, under this statute, appellees had the affirmative duty to create less restrictive community residential settings for them; however there is no contention that these class members, because of their handicap, are being denied access to community residential living that the State of Illinois is affording to others"). See also Conner v. Branstad, 839 F.Supp. 1346, 1356 (S.D.Iowa 1993) (The denial of community-based habilitation services to individuals with mental disabilities does not constitute a viable cause of action under § 504).

Where, as is the case here, prior administrative and judicial interpretations have settled the meaning of the pertinent provisions of the Rehabilitation Act, repetition of the same language in the ADA indicates, as a general matter, Congressional intent to incorporate those administrative and judicial interpretations as well. Bragdon v. Abbott, 118 S.Ct. 2196, 2208. When the ADA was enacted, the "settled" administrative and judicial interpretation of the pertinent statutory and rule provisions was that §504 did not require either deinstitutionalization or the provision of services provided solely to individuals with disabilities in a most integrated community setting. Therefore, this interpretation was "incorporated" into the ADA, and the Eleventh Circuit erred in

determining that the contrary was true. This issue of law is of fundamental importance to the states for reasons set forth above, and should be addressed by this Court by the instant petition.

**ii. DOJ's administrative interpretation of the ADA, as embodied in the Integration Rule, is erroneous.**

As this Court has recently stated, in evaluating the correctness of an administrative interpretation of a statute:

Under that analysis, we first ask whether Congress has "directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." If we determine that Congress has not directly spoken to the precise question at issue, we then inquire whether the agency's interpretation is reasonable. (Emphasis supplied)

National Credit Union Admin. v. First Nat. Bank & Trust Co.,  
\_\_\_ U.S. \_\_\_, 118 S.Ct. 927, 938 (1998).

In the action below, the Eleventh Circuit relied upon three provisions of the "Findings and Purpose" section of the ADA, Title 42 U.S.C. §§12101(a)(2), (3) and (5), in concluding that the ADA required the provision of services in the most integrated community setting available. Section 12101(a)(2) provides:

historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.

§12101(a)(3) provides:



discrimination against individuals persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services.

Section 12101(a)(5) provides:

individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;

From these statutory subsections, the Eleventh Circuit inferred a Congressional intent to eliminate segregation of individuals with disabilities, and a corollary intent to eliminate institutionalization. However, a comprehensive review of the ADA will *not* reflect any Congressional mandate that individuals with disabilities presently residing in institutions be placed in integrated community settings. Furthermore, in the ADA Congress has not stated that institutionalization of individuals with disabilities for treatment of their disability is *per se* discrimination. 42 U.S.C. §§12101 *et seq.*

The provisions of §12101(a)(3) do not reflect any Congressional finding that "institutionalization" *per se* is discriminatory, but provide a "laundry list" of areas where discrimination persists. This statutory provision no more stands for the premise that institutionalization must be eliminated, than it stands for the premise that employment, housing, public accommodations, education, transportation, and health services

must be eliminated - because discrimination *can* occur in these settings as well. §12101(a)(3).

Thus, the only conceivable subsections of the Act that the Eleventh Circuit could have relied on in determining that Congress "directly spoke" to the issue of institutionalization would be §12101(a)(2) and (5), and again these subsections do not clearly express such an intent. Rather, these subsections appear to be directed toward the "separate but equal" treatment historically accorded individuals with disabilities. *See e.g.* 135 Cong. Rec. S10897 (9/7/89).<sup>12</sup> Congress was concerned that, historically, *separate* services, benefits and aids were provided to individuals with disabilities rather than affording them the option of participating in the same services, benefits or aids that were provided to persons without disabilities. *Such is not the circumstance here, where the services at issue are not offered to individuals who are not disabled.*

Given the lack of any express Congressional statement regarding deinstitutionalization, this Court must address the issue of whether the Eleventh Circuit's interpretation of the Integration Rule (requiring provision of inclusive community-based placements, where appropriate, for delivery of services, aids and

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<sup>12</sup>/In the Senate discussion regarding the ADA, Senator Metzenbaum stated:

Now, as we prepare to vote on the ADA, we face a decision. We're at a turning point. Do we want to extend civil rights protections to Americans with disabilities? Do we want to build on the great American promise of inclusion, and bring people with disabilities into the fold?

"Our failure to do so would be like turning back the clock. *It would be tantamount to dredging up a 'whites only' sign and hanging it at a nearby lunchcounter.*" *Id.* (Emphasis supplied)

benefits which are *only* provided to individuals with disabilities) is reasonable. Amici contend that such a construction is *not reasonable*.

Congress knows very well how to impose an integration mandate on the states. See e.g., Oberti v. Board of Education, 995 F.2d 1204 (3d Cir. 1993) (Individuals with Disabilities Education Act requires mainstreaming of disabled children). Also, Congress provided for an integration mandate in the ADA—but not in Title II and not one that affected states. In Title III, Congress required that services offered to the disabled by “public accommodations” be provided in an integrated setting.<sup>13</sup> Public accommodations, however, are defined as private entities, not public entities.<sup>14</sup> And even in this instance, Congress’ intention was only to eliminate separate-but-equal services to the disabled.

This Court has previously held on several occasions that the predecessor to the Americans with Disabilities Act, the Rehabilitation Act, was designed to provide evenhanded treatment between individuals with disabilities and nondisabled persons. Alexander v. Choate, 469 U.S. 287, 105 S.Ct. 712, 721-722, 83 L.Ed.2d 661 (1985); Southeastern Community College v. Davis, 442 U.S. 397, 99 S.Ct. 2361, 60 L.Ed.2d 980 (1979); Traynor v. Turnage, 485 U.S. 535, 108 S.Ct. 1372, 1382, 99 L.Ed.2d 618 (1988); and Bowen v. American Hosp. Ass’n, 476 U.S. 610, 106 S.Ct. 2101, 2119 (1986). The legislative history of Title II of the ADA confirms Congress’s intent to extend the Rehabilitation Act’s

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<sup>13</sup>Title 42 U.S.C. §12182(b)(1)(B): “Integrated settings.—Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.”

<sup>14</sup>*Id.*, §12181(7).

proscription to all state and local government programs and services, irrespective of funding. See H.R.Rep. No. 101-485(II), 101st Cong., 2d Sess. 84 (1990) U.S.Code Cong. & Admin.News 1990 pp. 267, 303, 366-367. The regulations implementing Title II “confirm the uniformity of interpretation between the ADA and the Rehab Act.” 28 C.F.R. § 35.130. Therefore, it follows that the ADA must be interpreted so as assure evenhanded treatment between individuals with disabilities and others. At least one circuit court, in addressing this issue, has concluded that the ADA reaches differences in treatment accorded disabled persons versus nondisabled persons only. Lincoln CERCPAC v. Health and Hospitals Corp., 147 F.3d 165 (2nd Cir. 1998).<sup>15</sup> This is in contrast to the Eleventh Circuit’s decision below that the ADA bars the states from providing public services for individuals with disabilities, *which services are not provided to individuals who are not disabled*, in a segregated setting. L.C., 138 F.3d, at 897.

To the extent that individuals sue for particular services which are *only* available to individuals with disabilities, and sue for those services in a community-based setting, no ADA violation exists. This is so because the ADA *does not incorporate any requirement or obligation that the state provide services to disabled persons, when those same services are not provided to nondisabled persons*.

**C. Alternatively, the statute violates the Tenth and Eleventh Amendments to the United States Constitution.**

At pages 12-16 of the Petition, Petitioners assert that if the Eleventh Circuit has properly construed the reach of the ADA and

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<sup>15</sup>This decision supports Petitioner’s argument that there exists a conflicts between the circuits on the issues presented below. Petition, pp. 6-10.



its Integration Rule, then the ADA conflicts with this Court's holdings on §5 of the Fourteenth Amendment to the United States Constitution. This argument is essentially one that the ADA violates the Tenth and Eleventh Amendments to the United States Constitution.

Title 42 U.S.C. §12101(b)(4) provides the following statement of Congressional purpose supporting the ADA:

to invoke the sweep of congressional authority, including **the power to enforce the fourteenth amendment and to regulate commerce**, in order to address the major areas of discrimination faced day-to-day by people with disabilities.  
(Emphasis supplied)

Title II of the ADA, which is implicated in this action, is clearly adopted pursuant to the authority of §5 of the Fourteenth Amendment. Amos v. Maryland Dept. of Public Safety and Correctional Services, 126 F.3d 589, 617 (4th Cir. 1997).

Congress has broad power to enforce the Fourteenth Amendment. In Ex Parte Virginia, 100 U.S. 339, 345-346, 25 L.Ed.2d 676 (1879), this Court described the reach of the legislative power under §5: "Whatever legislation is appropriate, that is, adapted to carry out the objects the amendments have in view, whatever tends to enforce submission to the prohibitions they contain, and to secure to all persons the enjoyment of perfect equality of civil rights and the equal protection of the laws against state denial or invasion, if not prohibited, is brought within the domain of congressional power."

However, "[a]s broad as the congressional enforcement power is, it is not unlimited." City of Boerne v. Flores, \_\_\_ U.S. \_\_\_, 117

S.Ct. 2157, 2163, 138 L.Ed.2d 624 (1997) (quoting Oregon v. Mitchell, 400 U.S. 112, 91 S.Ct. 260, 27 L.Ed.2d 272 (1970)). That power is "remedial" in nature, and is limited to enforcing the provisions of the Fourteenth Amendment to the United States Constitution. Boerne, *supra*. Congress lacks the constitutional authority to legislate the substance of the Fourteenth Amendment. Id. It is critical that these boundaries of Congressional authority be observed, because of the powerful constraints the Tenth Amendment to the federal Constitution places on the powers of the United States. Civil Rights Cases, 109 U.S. 3, 14-15, 3 S.Ct. 18, 24, 27 L.Ed. 835 (1883).

Given the above-described principles, if a federal statute like the ADA is to confer upon persons a right to sue the states over nonenforcement of particular terms (or alternatively obligates the states to comply with a federal regulatory scheme), then the statute must find some authority in the Constitution under which the states have ceded sovereignty over such affairs to the federal government.

Amici assert that the ADA exceeds the authority of §5 of the Fourteenth Amendment, to the extent that it is applied to the states and *is interpreted to require the states to provide substantive services to individuals with disabilities, when those services are not provided to nondisabled persons*. Clearly, there exists no duty to provide substantive services or services in the most integrated community setting under the Fourteenth Amendment, or indeed any other provision of the United States Constitution. *See e.g.* Youngberg v. Romeo, 102 S.Ct. 2452, 457 U.S. 307, 73 L.Ed.2d 28 (1982) (State has considerable discretion in determining the scope and nature of the services it will provide, and need only exercise professional judgment in determining which services are appropriate).

It would appear that the ADA is now being used in ways that Congress neither anticipated nor authorized. If the Eleventh Circuit's interpretation of the ADA and the Integration Mandate is correct, the present interpretation of the ADA will have catastrophic effects on the states' fiscs. To the extent that the language of the ADA can somehow be interpreted to require that the states provide services (which are only provided to individuals with disabilities) in the most integrated community setting, then it is imperative that this Court consider now whether Congress exceeded its §5 authority in enacting the statutory scheme, and has improperly intruded on the sovereignty of the states.

### **CONCLUSION**

The Amici urge this Court to grant certiorari review and reverse the opinion of the Eleventh Circuit Court of Appeals below.

Respectfully submitted,

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### **INDEX TO APPENDIX**

|            |  |     |
|------------|--|-----|
| Appendix   | Department of Health and Human Services Letter to State Medicaid Director dated July 29, 1998 .....              | 1a  |
| Appendix B | U.S. Department of Justice Letter to Mr. Michael Auberger and Mr. Bob Kafka dated July 6, 1998 .....             | 5a  |
| Appendix C | Independence Now, Inc., Letter to Dr. Martin Wasserman dated August 28, 1998 .....                               | 7a  |
| Appendix D | United Way of Center Maryland Letter to Dr. Martin Wasserman of DHMH dated August 27, 1998 .....                 | 9a  |
| Appendix E | Department of Health and Human Services Medicaid Letter No. 98-24 dated September 2, 1998 .....                  | 11a |
| Appendix F | American Public Human Services Association Memorandum to State Medicaid Directors dated September 16, 1998 ..... | 15a |
| Appendix G | ADAPT Letter to Dr. Martin Wasserman dated September 9, 1998 ..  | 17a |
| Appendix H | ADAPT Letter to Mary Pat Farkas dated September 12, 1998 .....   | 19a |



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Health Care Financing Administration

Center for Medicaid and State Operations

7500 Security Boulevard  
Baltimore, MD 21244-1850

July 29, 1998

Dear State Medicaid Director:

In the Americans with Disabilities Act (ADA), Congress provided that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." 42 U.S.C. § 12101(a)(8). Title II of the ADA further provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs or activities of a public entity, or be the subject of discrimination by any such entity." 42 U.S.C. § 12132. Department of Justice regulations implementing this provision require that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d).

We have summarized below three Medicaid cases related to the ADA to make you aware of recent trends involving Medicaid and the ADA.

In L.C. & E.W. v. Olmstead, patients in a State psychiatric hospital in Georgia challenged their placement in an institutional setting rather than in a community-based treatment program. The United States Court of Appeals for the Eleventh Circuit held that placement in an institutional setting appeared to violate the ADA because it constituted a segregated setting,

and remanded the case for a determination of whether community placements could be made without fundamentally altering the State's programs. The court emphasized that a community placement could be required as a "reasonable accommodation" to the needs of disabled individuals, and that denial of community placements could not be justified simply by the State's fiscal concerns. However, the court recognized that the ADA does not necessarily require a State to serve everyone in the community but that decisions regarding services and where they are to be provided must be made based on whether community-based placement is appropriate for a particular individual in addition to whether such placement would fundamentally alter the program.

In Helen L. v. DiDario, a Medicaid nursing home resident who was paralyzed from the waist down sought services from a State-funded attendant care program which would allow her to receive services in her own home where she could reside with her children. The United States Court of Appeals for the Third Circuit held that the State's failure to provide services in the "most integrated setting appropriate" to this individual who was paralyzed from the waist down violated the ADA, and found that provision of attendant care would not fundamentally alter any State program because it was already within the scope of an existing State program. The Supreme Court declined to hear an appeal in this matter; thus, the Court of Appeals decision is final.

In Easley v. Snider, a lawsuit, filed by representatives of persons with disabilities deemed to be incapable of controlling their own legal and financial affairs, challenged a requirement that beneficiaries of their State's attendant care program must be mentally alert. The Third Circuit found that, because the essential nature of the program was to foster independence for individuals limited only by physical disabilities, inclusion of individuals incapable of controlling their own legal and financial affairs in the program would constitute a fundamental

alteration of the program and was not required by the ADA. This is a final decision.

While these decisions are only binding in the affected circuits, the Attorney General has indicated that under the ADA States have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. Reasonable steps should be taken if the treating professional determines that an individual living in a facility could live in the community with the right mix of support services to enable them to do so. The Department of Justice recently reiterated that ADA's "most integrated setting" standard applies to States, including State Medicaid programs.

States were required to do a self-evaluation to ensure that their policies, practices and procedures promote, rather than hinder integration. This self-evaluation should have included consideration of the ADA's integration requirement. To the extent that any State Medicaid program has not fully completed its self-evaluation process, it should do so now, in conjunction with the disability community and its representatives to ensure that policies, practices and procedures meet the requirements of the ADA. We recognize that ADA issues are being clarified through administrative and judicial interpretations on a continual basis. We will provide you with additional guidance concerning ADA compliance as it becomes available.

I urge you also, as we approach the July 26 anniversary of the ADA, to strive to meet its objectives by continuing to develop home and community-based service options for persons with disabilities to live in integrated settings.

If you have any questions concerning this letter or require technical assistance, please contact Mary Jean Duckett at (410) 786-3294.



Sincerely,

/s/

Sally K. Richardson

Director

cc: All HCFA Regional Administrators

All HCFA Association Regional Administrators for Medicaid  
and State Operations

Lee Partridge

Director, Health Policy Unit  
American Public Welfare Association  
810 First Street, N.W.  
Washington, DC 20002-4205

Joy Wilson

Director, Health Committee  
National Conference of State Legislatures  
Hall of the States  
444 N. Capital Street, N.W. Suite 515  
Washington, DC 20001

Jennifer Baxendell

National Governor Association  
Hall of the States  
444 N. Capital Street, N.W. Suite 267  
Washington, DC 20001

U. S. Department of Justice

Civil Rights Division

Disability Rights Section

Post Office Box 66738

Washington, D.C. 20035-6738

July 6, 1998

Mr. Michael Auberger

ADAPT

Post Office Box 9598

Denver, Colorado 80209

Mr. Bob Kafka

ADAPT of Texas

1339 Lamar Square Drive

Suite 101

Austin, Texas 78704

Dear Mr. Auberger and Mr. Kafka:

Thank you for your letter seeking clarification of the Americans with Disabilities Act's (ADA) self-evaluation requirements as they relate to the "integration mandate" of title II.

The ADA requires every public entity to conduct a self-evaluation of its "current services, policies, and practices, and the effects thereof, that do not meet the requirements of [the

title II regulations] . . . ." 28 C.F.R. 35.105(a). One of the fundamental requirements of the title II regulations is that public entities "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. 35.130(d).

This integration requirement applies to all State activities, including the provision of nursing home, institutional, and community-based services to people with disabilities. L. C. v. Olmstead, No. 97-8358 (11th Cir. April, 8, 1998); Helen L. v. DiDario, 46 F.3d 325 (3d Cir. 1995). Therefore, a State must review, as part of its self-evaluation, its policies and practices regarding the provision of nursing home, institutional, and community-based services to ensure that individuals with disabilities receive services in the most integrated setting appropriate to their needs.

If a State has failed to address the ADA's integration requirement in its self-evaluation, then its self-evaluation is incomplete. In these circumstances, it would be appropriate for state officials to address the integration issue. As provided in the Department's implementing regulation at 28 C.F.R. 35.105(b), interested persons, including individuals with disabilities or organizations representing individuals with disabilities, must be given an opportunity to participate in the self-evaluation process.

Sincerely,

/s/

John L. Wodatch

Chief

Disability Rights Section

Independence Now, Inc.

818 Roeder Road

Suite 202

Silver Spring, Maryland 20910

Voice: 301-587-4162 / FAX: 301-588-3951

TDD for Disabled: Maryland Relay Service 1-800-735-2258

Martin P. Wasserman, M.D., J.D.

Secretary

Department of Health and Mental Hygiene

201 West Preston Street

Baltimore, Maryland 21201

August 28, 1998

Dear Dr. Wasserman:

In a July 29, 1998 letter to all State Medicaid Directors, Sally Richardson of the Health Care Financing Administration reminded States of their responsibilities under the Americans Disabilities Act to provide services for people with disabilities in the most integrated settings. With that goal in mind, I am writing to request a copy of the [sic] your Department's self-evaluation plan (specific to the Medicaid program) required under the Americans with Disabilities Act. Further, I would like to know how the Department secured comments on the plan from the disability community. I will appreciate receiving this information by September 15, 1998.



Thank you.

Sincerely,

/s/

Catherine A. Raggio

Executive Director

cc: Bea Rodgers

United Way of Center Maryland

5807 Harford Road

Baltimore, Maryland 21214

(410) 444-1400

FAX (410) 444-0825

TTY Use: (800) 735-2258

August 27, 1998

Martin Wasserman, MD JD

Department of Health & Mental Hygiene

201 W. Preston Street Suite 500

Baltimore, Maryland 21201

Dear Secretary Wasserman:

In your role as Maryland's Medicaid Director, I would appreciate your sending me a copy of Maryland's ADA Self-Evaluation Plan (under Title II of the Americans with Disabilities Act). I am especially interested in seeing the details of how the Plan deals with the provision of nursing home, institutional and community-based services to people with disabilities in the most integrated setting appropriate.

I would further appreciate your sending me a copy of the Plan within the next ten (10) days.

In anticipation of receiving this information from you, I remain,

Sincerely,

/s/

Frank Printer

Executive Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Region III

Health Care Financing Administration

Suite 216, The Public Ledger Bldg.

150 S. Independence Mall West

Philadelphia, Pennsylvania 19106

September 2, 1998

MEDICAID LETTER NO: 98-24

SUBJECT: Questions Concerning the Helen L. State  
Medicaid Directors Letter

On July 29, 1998, the Director of the Center for Medicaid and State Operations wrote to advise you of recent trends involving Medicaid and the Americans with Disabilities Act (ADA). She noted that the Attorney General has indicated that under the ADA, States have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs. Pursuant to the ADA, reasonable steps should be taken if the treating professional determines that an individual living in a facility could live in the community with the right mix of support services to enable them to do so. According to the Department of Justice, the ADA's "most integrated setting" standard applies to States, including State Medicaid programs. The letter also summarized three Medicaid cases related to the ADA, two of which are binding in the third circuit which includes Pennsylvania, New Jersey and Delaware.



The Director discussed the federal regulation at 28 C.F.R. § 33.105 (reproduced below) establishing a requirement, based on the § 504 regulations for federally assisted and federally conducted programs that a public entity evaluates its current policies and practices to identify and correct any that are not consistent with the requirements of this part. The purpose of the self-evaluation is to ensure that your policies, practices and procedures promote, rather than hinder integration. This self-evaluation should have included consideration of the ADA's integration requirement. She also advised that, to the extent your State Medicaid program has not fully completed its self-evaluation process, you should do so now, in conjunction with the disability community and its representatives to ensure that policies, practices and procedures meet the requirements of the ADA. Experience has demonstrated the self-evaluation process to be a valuable means of establishing a working relationship with individuals with disabilities, which has promoted both effective and efficient implementation of § 504.

#### 35.105 Self-evaluation.

(a) A public entity shall, within one year of the effective date of this part, evaluate its current services, policies, and practices, and the effects thereof, that do not or may not meet the requirements of this part and to the extent modification of any such services, policies, and practices is required, the public entity shall proceed to make the necessary modifications.

(b) A public entity shall provide an opportunity to interested persons, including individuals with

disabilities or organizations representing individuals with disabilities, to participate in the self-evaluation process by submitting comments.

(c) A public entity that employs 50 or more persons shall, for at least three years following completion of the self-evaluation, maintain on file and make available for public inspection:

(1) A list of the interested persons consulted;

(2) A description of areas examined and any problems identified; and

(3) A description of any modifications made.

(d) If a public entity has already complied with the self-evaluation requirement of a regulation implementing section 504 of the Rehabilitation Act of 1973, then the requirements of this section shall apply only to those policies and practices that were not included in the previous self-evaluation.

Since the July 29, 1998, SMD letter, we have received questions concerning the letter and the ADA requirements. While we do not have all the answers at this point, we will be working with our Office of General Council and the Department of Justice to clarify as many issues/questions as possible. In this light, we would like to ascertain if you have any questions about the July 29 letter and other related ADA issues. Please provide a list of such questions to Bill Davis

of my staff by September 8, 1998. Bill's phone number is (215) 861-4204 and his E-mail address is Wdavis@HCFA.gov.

Sincerely,

/s/

Claudette V. Campbell

Associate Regional Administrator

Division of Medicaid and State Operations

American Public Human Services Association  
National Association of State Medicaid Directors

September 16, 1998

To: State Medicaid Directors

From: Bruce Bullen

Re: ADA Lawsuits

By now, you are aware of the debate over how recent judicial interpretations of the Americans with Disabilities Act (ADA) may seriously impact state Medicaid programs. Both the July 29th Dear State Medicaid Director letter from Sally Richardson, and the July 6th letter from the Department of Justice to ADAPT have brought this issue to national attention.

Most states, if not all, have already been contacted by disability advocates asking for self-evaluations of each state's policies and practices regarding the provision of nursing home, institutional, and community-based services to ensure that individuals with disabilities receive services in the "most integrated setting appropriate to their needs."

Some states have heard, both from ADAPT and from sources within HRS, that it is the beneficiary and his/her family, and not the state or clinicians that will ultimately decide what the "most integrated setting appropriate" will be.



Potential implications include: waiting lists under the 1915 (c) waivers could well be determined to be a violation of ADA; and states could be faced with the creation of an entitlement to community care *in addition* to the current entitlement to institutional care. Ultimately, states could be faced with significantly raising taxes to pay for care, making eligibility criteria so strict that fewer people can get services, or even dismantling their 1915 (c) waiver programs entirely.

The Executive Committee of NASMD is taking this issue very seriously and is currently consulting with staff attorneys to determine if the Justice Department's interpretation of the ADA is valid, and what our legal options will be.

We will continue to keep you aware of our attempts to reach consensus on this issue.

ADAPT

234 Lord Byron Lane  
Texas, Maryland 21030  
(410) 666-5484  
FAX: (410) 666-5080

September 9, 1998

Martin P. Wasserman, M.D., J.D.  
Secretary, Department of Health & Mental Hygiene  
201 West Preston Street  
Baltimore, Maryland 21201

re: "Most Integrated Setting"

Dear Dr. Wasserman:

ADAPT requests you do the following:

- 1) Give us a copy of Maryland's most current self-evaluation conducted to comply with 28 C.F.R. 35.105 (a), including Maryland's evaluation with respect to nursing facilities and ICF-MR's, as required by 28 C.F.R. 35.130 (d). **This is our third request;**

- 2) Provide us a written commitment that no person with a disability will ever be forced into an institution because of lack of funding for community services;
- 3) Write a letter with ADAPT informing ALL folks in nursing homes, ICF-MR facilities and other institutions about their options for community services and consumer community organizations of people with disabilities that can give them information;
- 4) Fund a training [sic] designed by ADAPT for consumers who can help folks getting out of nursing homes, ICF-MR facilities and other institutions.
- 5) Please respond by fax on or before Monday, September 14th, by 2 p.m. People have a right to be free.

There's No Place Like Home!

/s/

Crosby King, ADAPT, and other ADAPT freedom speakers

cc: Maryland Disability Law Center  
National ADAPT  
Governor Glendening

ADAPT  
234 Lord Byron Lane  
Texas, Maryland 21030  
(410) 666-5484  
FAX: (410) 666-5080

September 12, 1998

Mary Pat Farkas, Special Assistant  
MCPA-MDHMH  
201 W. Preston Street  
Baltimore, Maryland 21201

Re: Maryland's Title II Self-Evaluation

Dear Ms. Farkas:

We got your letter dated September 9, 1998 on the 11th saying that staff are working on a draft and that a copy of the self evaluation would be forwarded as soon as it is complete. We have not received a response to our third request, however, also dated Sept. 9th, wherein we made it quite clear that a more complete response is required at this point.

The Americans with Disabilities Act (ADA) states that programs must be provided in the "most integrated setting" and must offer the "least restrictive alternative" in service delivery. This law was tested in Pennsylvania's Medicaid



nursing home program, when in 1995 the Supreme Court let stand the 3rd Circuit Court's decision on the case of Helen L. She was a woman forced to live in a nursing home under the Medicaid program, because no other choices were offered to her. The Court decided in her favor. She now lives free, in her own home, with appropriate needed services. The TWO Marylanders for whom we filed civil rights complaints on Sept. 10, 1998 are still incarcerated in nursing homes for the crime of disability.

A component of the Self Evaluation is supposed to address how Maryland's policies, practices and procedures promote rather than hinder full integration in the community. According to a July 29, 1998 letter by Sally Richardson HCFA Director to all State Medicaid Directors, the self evaluation should have included consideration of the ADA's integration requirement. **"The State has an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs.** Reasonable steps should be taken if the treating professional determines that an individual living in a facility could live in the community with the right mix of support services to enable them to do so. The Department of Justice recently reiterated that the ADA's most integrated setting standard applies to States, including State Medicaid Program." (emphasis added)

Moreover, Maryland was required to have completed the self evaluation six years [sic] and is NOW required to do so "in conjunction with the disability community . . . to ensure that policies, practices and procedures meet the requirements of the ADA."

ADAPT has sent three letters to Secretary Wasserman to request the ADA Self-evaluation Plan, as it relates to most integrated setting for services now offered in nursing homes and ICF-MRs. With this fourth letter, Maryland ADAPT demands immediate review of any drafts as they relate to most integrated setting, including action plan timetables for compliance with integrating people into their communities.

FREE OUR PEOPLE!

/s/

Crosby King

Organizer

cc: The Honorable Martin P. Wasserman, M.D., J.D.  
Joseph Millstone  
John Wodatch  
MDLC  
National ADAPT

18  
No. 98-536

Supreme Court, U.S.

FILED

FEB 4 1999

In The  
**Supreme Court of the United States**  
October Term, 1998

TOMMY OLMSTEAD, et al.,

v. *Petitioners,*

L.C. and E.W., each by JONATHAN ZIMRING  
as guardian ad litem and next friend,

*Respondents.*

On Writ Of Certiorari To The United States Court  
Of Appeals For The Eleventh Circuit

**JOINT APPENDIX**

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*Counsel for Petitioners*

**Petition For Certiorari Filed September 29, 1998**  
**Certiorari Granted December 14, 1998**



JOINT APPENDIX  
TABLE OF CONTENTS

|  | Page |
|--|------|
| Relevant Docket Entries.....   | 1    |
| Complaint (R1) <sup>1</sup> , filed May 11, 1995.....  | 2    |
| Affidavit Excerpt: Kimble, Exhibit B to Plaintiff's<br>Brief in Support of Motion for Temporary<br>Restraining Order and Injunction (R5), filed May<br>30, 1995 .....  | 30   |
| Georgia Regional Hospital at Atlanta Record<br>Excerpt re: L.C., Exhibit E-3 to Plaintiffs' Brief<br>In Support of Motion for Temporary Restraining<br>Order and Preliminary Injunction (R5), filed<br>May 30, 1995..... | 32   |
| Affidavit of Brazee, Exhibit 29 to Plaintiff L.C.'s<br>Motion for Temporary Restraining Order (R5),<br>filed May 30, 1995.....   | 33   |
| Answer and Defenses (R7), filed June 2, 1995 .....   | 41   |
| Intervenor's Complaint (R11), motion filed June<br>16, 1995; (Motion granted January 29, 1996).....  | 61   |
| Excerpt from Consent Order (R19), filed August 4,<br>1995 .....  | 75   |
| Defendants' Responses to Intervenor's Complaint<br>(R29), filed February 20, 1996.....   | 76   |
| Paragraphs from Plaintiffs' Statement of Material<br>Facts (R59), filed August 20, 1996.....   | 88   |
| Affidavit Excerpt: Elliott, Exhibit 1 to Plaintiff's<br>Statement of Material Facts (R59), filed August<br>20, 1996 .....  | 94   |

---

<sup>1</sup> References to the District Court record docket entries are denoted as (R#).

JOINT APPENDIX  
TABLE OF CONTENTS – Continued

|   | Page |
|---|------|
| Affidavit Excerpt: Elliott, Exhibit 9 to Plaintiff's Statement of Material Facts (R59), filed August 20, 1996 .....   | 95   |
| Excerpt from Debacher evaluation of E.W., Exhibit 6 to Plaintiffs' Statement of Material Facts, filed August 20, 1996 .....   | 101  |
| Letter dated March 20, 1995, attached to Plaintiffs' Motion for Summary Judgment (R59), filed August 20, 1996 .....   | 102  |
| Affidavit of Patel, attached to Defendants' Brief in Support of Motion for Summary Judgment (R61), filed August 22, 1996 .....  | 104  |
| Affidavit of Pittman, attached to Defendants' Brief in Support of Motion for Summary Judgment (R61), filed August 22, 1996 .....  | 115  |
| Georgia Regional Hospital at Atlanta Record Excerpt re: E.W., Exhibit 1 to Plaintiffs' Response to Defendants' Motion for Summary Judgment (R68), filed September 13, 1996 .....  | 118  |
| Excerpts from Defendants' Response to Plaintiffs' Motion for Summary Judgment (R65), filed September 13, 1996 .....   | 120  |
| Affidavit of Futral, Exhibit 1 to Plaintiffs' Response to Defendants' Supplemental Brief In Support of Defendants' Motion for Summary Judgment and in Opposition to Plaintiffs Motion for Summary Judgment (R79), filed March 3, 1997 ..... | 121  |
| Affidavit of Cobb, Exhibit 3 to Plaintiffs' Response to Defendants' Supplemental Brief In Support of Defendants' Motion for Summary Judgment and in Opposition to Plaintiffs Motion for Summary Judgment (R79), filed March 3, 1997 .....   | 128  |

JOINT APPENDIX  
TABLE OF CONTENTS – Continued

|  | Page |
|--|------|
| Affidavit of Roland, Exhibit B to Defendants' Motion To Stay Judgment (R85), filed April 17, 1997 .....  | 135  |
| Affidavit of Horton, M.D., Exhibit C to Defendants' Motion to Stay Judgment (R88) filed 4/17/97 .....  | 142  |
| CSH Consultation Excerpt, Exhibit 4 attached to Plaintiffs' Response to Defendants' Motion to Stay Judgment (R88) filed 5/2/97 .....                           | 146  |
| Affidavit of Ackerman, Exhibit 7 to Plaintiffs' Response to Defendants' Motion to Stay Judgment (R88), filed May 2, 1997 .....                                 | 150  |
| Second Affidavit of Pittman, attached to Defendants' Reply to Motion To Stay Judgment (R90), filed May 19, 1997 .....  | 153  |
| Second Affidavit of Horton, attached to Defendants' Reply to Motion To Stay Judgment (R90), filed May 19, 1997 .....   | 155  |
| Projected Service Costs for L.C., Plaintiffs' Response to Defendants' Motion to Stay Judgment, filed in the Eleventh Circuit Court of Appeals June 6, 1997 ... | 158  |
| Excerpt from Defendants' Petition for Rehearing and Suggestion of Rehearing En Banc, filed in the Eleventh Circuit Court of Appeals April 29, 1998 .....       | 159  |
| Affidavit of Cobb, attached to Plaintiffs' Brief on Remand (R105), filed October 9, 1998 .....   | 160  |
| Excerpt from "Evaluation of Brook Run", Exhibit to Plaintiffs' Brief On Remand (R105), filed October 9, 1998 .....   | 165  |



JOINT APPENDIX  
TABLE OF CONTENTS – Continued

|  | Page |
|--|------|
| Excerpt from "Expanding Georgia's Community Services," Georgia Department of Human Resources, July, 1997, Exhibit to Plaintiffs' Brief On Remand (R105), filed October 9, 1998 .....   | 167  |
| Newspaper article, "State Urging Leaner Mental Hospitals," attached in Exhibit to Plaintiffs' Brief On Remand (R105), filed October 9, 1998 ...  | 174  |
| Order of District court granting Plaintiffs' Motion in Limine on Remand (R107), filed October 20, 1998 ...   | 176  |
| Excerpt from "Opening the Gateway to the Future," 1997 Annual Report, Georgia Department of Human Resources, Exhibit to Defendants' Brief on Remand (R111), filed October 29, 1998 .....   | 178  |
| Excerpt from "A Call For Resolve: Fulfilling Our Promise, Final Report of the State Commission on Mental Health, Mental Retardation, and Substance Abuse Service Delivery," December 1996, Exhibit to Defendants' Brief on Remand (R111), filed October 29, 1998 ..... | 186  |
| Excerpt from "Hospital Resources Allocation Task Force, Final Report," November 1997, Exhibit to Defendants' Brief on Remand (R111), filed October 29, 1998 .....  | 191  |
| Excerpt from "The Path Ahead, A Two Year Plan of the Department of Human Resources, Division of Mental Health, Mental Retardation, and Substance Abuse, June 1997," Exhibit to Defendants' Brief on Remand (R111), filed October 29, 1998 .....                        | 193  |
| Affidavit of Benson, Exhibit to Defendants' Brief on Remand (R111), filed October 29, 1998 .....   | 195  |

JOINT APPENDIX  
TABLE OF CONTENTS – Continued

|  | Page |
|--|------|
| DEPOSITION EXCERPTS:   |      |
| Ramesh N. Amin, December 13, 1995 .....  | 204  |
| Dilipkumar Patel, December 13, 1995 .....  | 205  |
| Charles B. Hopkins, January 10, 1996 .....   | 207  |
| Tommy Olmstead, January 30, 1996 .....   | 208  |
| Jimmie Parrish, March 11, 1996 .....   | 208  |
| Dilipkumar Patel, March 12, 1996 .....   | 210  |
| Gary DeBacher, March 12, 1996 .....  | 213  |
| Richard Elliott, April 9, 1996 .....   | 214  |
| Charles William Bliss, May 10, 1996 .....  | 215  |
| Joseph Steed, May 23, 1996 .....   | 216  |
| THE FOLLOWING ITEMS were found in the original Petition for Writ of Certiorari:                  |      |
| Decision of the United States District Court for the Northern District of Georgia, Pet. App. 31a |      |
| Opinion of the Court of Appeals, Pet. App. 1a  |      |
| Denial of Motion for Rehearing and Suggestion of Rehearing En Banc, Pet. App. 43a                |      |

## RELEVANT DOCKET ENTRIES

*L.C. et al. v. Olmstead et al.*, United States District Court for the Northern District of Georgia, Civil Action No. 1:95-CV-1210-MHS

5/11/95 COMPLAINT.

6/2/95 ANSWER.

6/16/95 MOTION by E.W. to intervene.

2/20/96 RESPONSE TO Intervenor's Complaint.

8/20/96 PLAINTIFFS' MOTION For Summary Judgment.

8/22/96 DEFENDANTS' MOTION For Summary Judgment.

3/26/97 ORDER AND JUDGMENT.

4/17/97 DEFENDANTS' MOTION to Stay Judgment.

5/22/97 ORDER denying Defendants' Motion to Stay Judgment.

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

|                                |   |               |
|--------------------------------|---|---------------|
| L.C., by JONATHAN ZIMRING      | ) |               |
| as guardian ad litem and next  | ) |               |
| friend,                        | ) |               |
| Plaintiff,                     | ) | CIVIL ACTION  |
| v.                             | ) | FILE NO.      |
|                                | ) | 1 95-CV-1210- |
|                                | ) | <u>MHS</u>    |
| TOMMY OLMSTEAD,                | ) |               |
| Commissioner of the Department | ) |               |
| of Human Resources; RICHARD    | ) |               |
| FIELDS, Superintendent of      | ) |               |
| Georgia Regional Hospital at   | ) |               |
| Atlanta; and ERNESTINE         | ) |               |
| PITTMAN, Executive Director of | ) |               |
| the Fulton County Regional     | ) |               |
| Board, all in their official   | ) |               |
| capacities,                    | ) |               |
| Defendants.                    | ) |               |

COMPLAINT

(Filed May 11, 1995)

I.

INTRODUCTION

1.

Plaintiff, L.C., a 27 year old mentally retarded person, brings this action challenging her continued confinement at Georgia Regional Hospital at Atlanta ("GRH-A"). GRH-A is a state hospital for persons suffering from acute psychiatric illnesses. GRH-A is *not* a hospital for the habilitation of persons with mental retardation. Although

Plaintiff was confined in May, 1992, for treatment of schizophrenia, she no longer requires inpatient psychiatric treatment.

2.

Despite the professional judgment of her psychiatric treatment team that L. C. no longer requires confinement for treatment of her mental illness and needs community residential and habilitation services, Defendants have continued to forcibly confine Plaintiff to GRH-A.

3.

Because Plaintiff's mental illness no longer serves as a basis for her involuntary hospitalization, Plaintiff's continued confinement is clearly based solely on her disability, mental retardation. This constitutes illegal discrimination against the disabled.

4.

Because Defendants have subjected Plaintiff to prolonged and unnecessary confinement in a mental hospital and thus deprived her of minimal habilitation in an appropriate setting, her condition has regressed, she has lost basic self-care and adaptive living skills, and she has failed to maintain or develop other skills fundamental to her ability to function outside of an institution.

4

5.

Defendants have therefore violated Plaintiff's constitutional and statutory rights to freedom from undue restraint, minimally adequate treatment, freedom from illegal discrimination, and placement in the most integrated setting appropriate to her needs under the Fourteenth Amendment to the U.S. Constitution, the Americans with Disabilities Act, and 42 U.S.C. § 1983. Thus, Plaintiff seeks immediate declaratory and injunctive relief requiring Defendants to release her from GRH-A, place her in the most integrated setting appropriate to her needs, and provide her with the appropriate treatment and services.

## II.

### JURISDICTION

6.

This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1343 and 42 U.S.C. § 12133 in that this is an action arising under the Americans with Disabilities Act, the Fourteenth Amendment to the United States Constitution, and 42 U.S.C. § 1983.

7.

This Court has jurisdiction to award declaratory and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202 and 42 U.S.C. § 1983.

5

8.

Venue is proper under 28 U.S.C. § 1391.

## III.

### PARTIES

9.

Plaintiff, L.C. , is twenty-seven years old and has a diagnosis of mental retardation and schizophrenia or schizoaffective disorder. Her psychiatric symptoms have been controlled adequately for over two years and she does not require inpatient psychiatric hospitalization. In spite of the evaluations and professional judgments of L.C.'s treatment staff that Plaintiff does not require hospitalization but needs community residential and habilitation services, Defendants have refused to provide such services. Thus, Plaintiff remains hospitalized at GRH-A, a hospital for persons with active mental illness, solely by reason of her mental retardation with little or no provision of habilitation that is related to her mental retardation. Plaintiff is a resident of Fulton County, Georgia.

10.

Defendant Tommy Olmstead is the Commissioner of the Department of Human Resources ("DHR") and is responsible for the operation of GRH-A, for the protection of the rights of persons confined to GRH-A, and for the overall provision of services to persons suffering from mental retardation and mental illness in the State of Georgia.



11.

Defendant Richard Fields is the Superintendent of GRH-A, located in DeKalb County, Georgia. As such, he is responsible for the operation of GRH-A, for the treatment of persons confined to GRH-A, and for the protection of rights of persons confined to GRH-A.

12.

Defendant Ernestine Pittman is the Executive Director of the Fulton County Regional Board (the "Board") and is responsible for the provision of mental health and mental retardation services, including community care and placement, for all residents of Fulton County.

## IV.

STATUTORY AND CONSTITUTIONAL FRAMEWORKA. The Americans with Disabilities Act

13.

In 1990, Congress enacted the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12101 *et seq.* Title II of that Act provides as follows:

. . . [N]o qualified individual with a disability, shall by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132.

14.

In passing this Act, Congress explicitly stated that the purposes of the ADA were:

- (a) *to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;*
- (b) *to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.*

42 U.S.C. § 12101(b)(1) & (4). (Emphasis added.)

15.

In defining this purpose, Congress made the following significant findings which are especially relevant to this case:

- (a) *historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;*
- (b) *discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization, health services, . . . and access to public services;*
- (c) *. . . individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;*

- (d) individuals with disabilities continually encounter various forms of discrimination, including . . . failure to make modifications to existing facilities and practices, . . . *segregation*, and relegation to lesser services. . . . ;
- (e) the Nation's proper goals regarding individuals with disabilities are to assure . . . *independent living* . . . .

42 U.S.C. § 12101(a)(2), (3), (4), (5), and (8). (Emphasis added.)

## 16.

The legislative history of the ADA comports with the statutory findings that unnecessary institutionalization and segregation is a destructive practice that Congress sought to end. This point is supported most eloquently by the testimony of Senator Lowell Weicker, the original sponsor of the ADA and former Chair of the Senate Subcommittee on the Handicapped:

For years, this country has maintained a public policy of protectionism toward people with disabilities. *We have created monoliths of isolated care in institutions and in segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal. It was not for black[s]; it is not for the disabled.*

ADA Hearing before the Senate Comm. on Labor and Human Resources and Subcomm. on the Handicapped, 101st Cong., 1st Sess. 215 (1989) (Emphasis added.)

## 17.

In keeping with the statutory language and legislative history, federal regulations implementing the ADA provide that:

A public entity shall administer services, programs, and activities *in the most integrated setting appropriate* to the needs of qualified individuals with disabilities.

28 C.F.R. § 35.130(d) (1993) (Emphasis added.)

B. The Fourteenth Amendment

## 18.

The Fourteenth Amendment to the U.S. Constitution provides in pertinent part:

. . . [N]or shall any state deprive any person of life, liberty, or property, without due process of law. . . .

C. Georgia Mental Health Code

## 19.

Georgia's Mental Health Code and implementing regulations provide that:

Each client in a facility and each person receiving services for mental retardation shall receive habilitation that is suited to his needs and is the least restrictive appropriate habilitation.

O.C.G.A. § 37-4-122(a); Chapter 290-4-6-02(1)(A), Ga. Admin. Code.



State law further provides with regard to the habilitation of persons with mental retardation:

It is the policy of the state that the least restrictive alternative placement be secured for every client at every stage of his habilitation. It shall be the duty of the facility to assist the client in securing placement in noninstitutional community facilities and programs.

O.C.G.A. § 37-4-121.

There are identical provisions of state law requiring individualized, least restrictive appropriate treatment and assistance in securing community placement for mentally ill persons. *See* O.C.G.A. § 37-3-162(a) and O.C.G.A. § 37-3-161.

A person receiving court-ordered services for mental retardation is entitled to an individual program plan for appropriate care, training, education, habilitation and other needed specialized services "written in behavioral terms" and containing, among other requirements, "a description of intermediate and long-range habilitation goals and a projected time-table for their attainment" and "an explanation of criteria for acceptance or rejection of alternative environments for habilitation." *See* O.C.G.A. § 37-4-40(c); O.C.G.A. § 37-4-2(9); Chapter 290-4-6-.01(4)(i), Ga. Admin. Code.

There are identical provisions of state law requiring the development of an individualized service plan for a mentally ill person "specifically tailored to the individual's treatment needs," and including among other requirements "identification of the types of professional personnel who will carry out the treatment." *See* O.C.G.A. § 37-3-64(c); O.C.G.A. § 37-3-1(9); Chapter 290-4-6.01(4)(i), Ga. Admin. Code.

Amendments to the state law, effective July 1, 1994, provide that the state office for mental health and mental retardation services:

... is authorized to move funds to and between community and institutional programs based on need. . . .

O.C.G.A. § 37-2-5-1(c)(3). Those amendments provide further that:

The State of Georgia recognizes its responsibility for its citizens who are mentally ill or mentally retarded . . . to meet their needs through a coordinated system of community facilities, programs, and services.

O.C.G.A. § 37-2-1(a).

Finally, the state law, "Community Services for the Mentally Retarded", mandates community-based services when "deemed reasonably necessary by the Department (of Human Resources) to provide for education, training,

rehabilitation, and care of mentally retarded individuals."  
See O.C.G.A. § 37-5-1 *et seq.*

## V.

FACTUAL ALLEGATIONS

25.

L.C. is a 27-year old African-American woman with mental retardation. In addition to mental retardation, she also has a diagnosis of schizophrenia or schizoaffective disorder. She is a friendly person with a beautiful smile, genuine artistic talent, and a remarkable enthusiasm for writing words on paper.

26.

L.C. is disabled.

27.

L.C. has consistently been diagnosed with mild or moderate mental retardation; she has only very elementary ability to read and write a few words and a very limited ability to understand abstract concepts.

28.

L.C. is currently residing on an adult psychiatric unit at Georgia Regional Hospital - Atlanta (GRH-A), a facility owned and operated by the State of Georgia; she has lived most of her life since age 14 at this facility and other institutions.

29.

GRH-A is a facility licensed and staffed to provide care and treatment for persons with psychiatric illnesses. Its programs are primarily designed to stabilize individuals during the acute phase of a mental illness so that ongoing mental health treatment can then be continued in the community on an outpatient basis.

30.

The average length of stay for a patient at GRH-A is 21 days, but L.C. has lived there for more than three years.

31.

GRH-A is a large institution with about 300 patients, divided into various units or wards; each of the adult psychiatric units has between 30 and 60 patients.

32.

The unit where L.C. lives is called the "treatment unit"; it is a longer term unit for patients who remain hospitalized for several weeks or months. The average number of patients on the unit is 65.

33.

In 1991, L.C. was placed in a community program for persons with mental retardation arranged by a non-profit



organization, Project Rescue, after many years of inappropriate psychiatric institutionalization at GRH-A from 1984 through 1991.

34.

L.C. lived quite successfully in that program for about one year.

35.

In May 1992, L.C. experienced a period of stress apparently related to a conflict with staff in the community program; she began expressing a desire to be hospitalized and began exhibiting some aggressive and psychotic behavior.

36.

In May 1992, L.C. was hospitalized at GRH-A for treatment of her mental illness.

37.

After L.C. was hospitalized, another person moved into her community residential "slot".

38.

The specific purpose of her admission to the hospital was to stabilize her psychiatric symptoms so that she could be returned to a community setting as soon as

possible. At that time, L.C.'s hospitalization was intended to be a brief period of inpatient treatment.

39.

At the time of her hospitalization, the hospital developed a treatment plan which focused on the stabilization of her mental illness. As early as June, 1993, L.C.'s treating physician at GRH-A concluded that the primary psychiatric treatment goal had been met.

40.

Once L.C.'s condition had stabilized, she no longer needed to be confined in an institution; she could have functioned from that point in a more integrated, community setting with adequate supervision.

41.

As early as November, 1992, staff began to regularly note that L.C.'s condition remains the same or "unchanged."

42.

In January, 1993, a social worker contacted "mental retardation services" for placement but there is no record of any response.

16

43.

In March, 1993, L.C.'s physician expressed his belief that because "she cannot live in the community without structure," he must "file for commitment."

44.

In April, 1993, L.C.'s physician noted that "placement remains a problem" and the team nurse stated that she is "stable awaiting placement."

45.

In July, 1993, L.C.'s physician was of the opinion that her need for "constant structure" was the "main problem preventing from placing her" and her nurse was of the opinion that she "remains the same, has reached maximum level of functioning. Placement is primary problem."

46.

In August, 1993, L.C.'s physician stated his belief that L.C.'s need for "constant reminder to keep her face clean" was a significant barrier to placement.

47.

In September, 1993, L.C.'s social worker told her that he will assist her in finding a "personal care home" placement.

17

48.

Up to the present time, Defendants have completely failed to place L.C. in an appropriate community residential setting outside the hospital.

49.

Once L.C.'s psychiatric condition had stabilized, her primary treatment and habilitation needs were related to her mental retardation. These needs could not be and were not adequately addressed at GRH-A.

50.

During the three years that L.C. has been confined in a mental hospital, no individualized habilitation program has been designed or implemented for her by qualified mental retardation professionals with training or experience in the habilitation of mentally retarded persons.

51.

For the first two years of L.C.'s confinement at GRH-A and for much of the time during her previous years in the institution, she would sit around in the day room areas doing nothing. From May, 1992, through August, 1994, her primary activities consisted of several hours a day in a pre-vocational program on the hospital grounds, a hygiene group and a communication group, each of which met for a total of two or three hours each week.



52.

Because L.C. is in a mental hospital, the policies, standards, and regulations applicable to the appropriate habilitation of mentally retarded persons in state, federal, and other publicly funded programs, such as those that govern the use of restraint, seclusion, medication, and the development and implementation of habilitation plans, have not been followed by her treating professionals at GRH-A.

53.

Upon information and belief, none of the professionals on L.C.'s treatment team at GRH-A are qualified mental retardation professionals with experience or training in the habilitation of mentally retarded persons nor has L.C. been evaluated by any such professional on the hospital staff during her three years at the hospital.

54.

L.C.'s hospital record reveals many instances of the staff's inappropriate responses to L.C., the absence of a consistent, professional approach to her behavioral problems, and a reliance by staff on psychotropic drugs to manage behavior.

55.

The record also reveals that the hospital staff was and is without basic information regarding both the capacity of mentally retarded persons to live in the community

with proper support and the capability of mental retardation community programs to deal with L.C.'s behavioral deficits.

56.

For example, L.C. was told that she cannot work unless she "keeps herself clean" and staff repeatedly commented that she takes many baths but does not wash properly. At the same time, her treatment team decided that she must show an ability to work successfully for an extended period of time before she can be considered for discharge. No professionally designed, consistent behavior management plan was designed to help L.C. learn how to keep clean.

57.

Hospital staff often control L.C. with the administration of sedatives or psychotropic drugs when she is loud and disruptive, but she has never been disruptive at the community day program which she began in August, 1994.

58.

In the professional judgment of two mental retardation assessment teams in 1986 and 1988 as well as the two GRH-A treating psychiatrists responsible for L.C.'s care, as well as the nurses and social workers that have been on her treatment team since May, 1992, long-term psychiatric hospitalization is inappropriate, unnecessarily restrictive, and does not meet her individual needs.

59.

In the professional judgment of L.C.'s treatment staff and an independent clinical psychologist, her long-term treatment and habilitation must be conducted in a less restrictive and more appropriate setting in the community and not on an inpatient psychiatric ward.

60.

L.C.'s confinement on a locked ward in a mental hospital is a degree of restraint on her freedom which is inconsistent with the professional judgment of mental retardation evaluators and her hospital treatment staff concerning her appropriate treatment.

61.

Despite the professional judgment of L.C.'s two treating physicians at GRH-A and other members of her treatment team at the hospital that L.C. should not continue to be confined in a mental hospital, it was and is the understanding and belief of all staff involved with her care that no alternative community residential placements are available and that, for this reason, L.C.'s only option is to remain in the hospital.

62.

Confinement in a mental hospital is detrimental to L.C. She pleads on a daily, sometimes hourly, basis to be released and expresses great sadness, hopelessness, and frustration that another place to live cannot be located.

This level of anxiety about her situation and uncertainty about her future interferes with her ability to function.

63.

During the past three years, while institutionalized, L.C. has lost basic self-care skills, such as the ability to use the bathroom on her own without constant reminders.

64.

L.C.'s mental condition has remained essentially unchanged during the past three years of confinement but her social skills, her self-care skills, her adaptive abilities, and her overall capacity to function in society have diminished.

65.

In addition to the past three years, L.C.'s many previous years of inappropriate institutional confinement during the period from 1985 through 1991 are a primary factor in her present need for a structured and supervised community placement to assist her in the transition to more independence.

66.

Since August, 1994, L.C. has participated in a community-based day program away from the hospital. In this environment, she has begun to show progress in areas of functioning, such as social skills, activities of



daily living, and the ability to express and control emotion, which had remained essentially unchanged since her admission to GRH-A in 1992.

67.

Minimal habilitation for L.C. would consist of specialized programs, training, and behavior management programs designed by mental retardation professionals to meet her individual needs.

68.

The minimally adequate setting for L.C.'s long-term habilitation is placement in the community.

69.

During the three years that L.C. has resided in the treatment unit at GRH-A, she has lived in an environment that is completely isolated and segregated from society; other than members of the hospital staff, she has virtually no contact with persons other than severely mentally ill persons in the acute phase of their illness.

70.

Because L.C. lives in an institution with mentally ill individuals, she has no opportunity to interact with non-disabled persons in daily activities and no opportunity to learn and maintain skills that would enhance her ability to become more integrated into society, such as riding a

bus, shopping, cooking, and doing simple housekeeping tasks.

71.

The state, through its county, regional, and contracted private providers operates a supervised, community-based residential program for persons with mental retardation. The cost of placement in a such a program is substantially less expensive than the cost of institutional care.

72.

The hospital administration, the state office for mental retardation services, as well as the county and regional mental retardation programs, have been aware of L.C.'s need for community services through many informal and formal efforts to secure these services.

73.

Because L.C. is both mentally retarded and mentally ill, she has received lower priority for community placement than persons whose diagnosis is exclusively mental retardation.

74.

There are existing vocational, habilitative, social, and residential programs in the community operated fully or in part by the Defendants with the necessary experience,

qualified staff, and the appropriate support and supervision to provide L.C. with the minimal habilitation that she needs in a much more integrated setting than her present institutional placement.

75.

One of these programs, TOPS, has assessed L.C. and would be willing to place her in a supervised home or apartment setting through the "personal support" medicaid waiver program if the state or county would provide the requisite "match" to secure the federal medicaid funds for implementation of an appropriate community habilitation program for L.C.

76.

The state and county have established many such placements with similar arrangements for other mentally retarded persons.

77.

During the period that L.C. has been confined at GRH-A, she received a \$14,000.00 lump sum Social Security payment in October, 1992; she also receives a regular monthly Social Security disability payment of \$380.00.

78.

The hospital, when informed of the lump sum payment, completed the necessary forms to become L.C.'s

payee so that the hospital would have the authority to spend the money for L.C.'s benefit.

79.

After becoming the payee for L.C.'s Social Security benefits, the hospital then initiated a second procedure pursuant to state law which would permit the application of the lump sum and monthly benefits to the cost of L.C.'s care at the hospital.

80.

These actions of the hospital resulted in the application of all of L.C.'s funds toward the cost of her institutional care rather than toward the cost of a community alternative, with the exception of a small monthly allowance to purchase cigarettes and a \$5,000.00 burial fund.

81.

Upon information and belief, the hospital failed to submit a claim for available medicare insurance coverage on L.C.'s behalf until recently when Plaintiff's attorney raised concerns about the hospital's application of all the funds available to L.C. for alternative placement to the cost of her institutional care.

82.

L.C. had a right to a hearing in the proceeding where the hospital became the payee for her Social Security



benefits and in the proceeding which resulted in the application of essentially all of her funds to her cost of care.

83.

Although notices regarding the procedures for requesting these hearings were received by the hospital, L.C. was not made aware of these notices in either proceeding and no hearings were requested or conducted on her behalf.

84.

At all times relevant to this Complaint, Defendants have acted under color of state law.

85.

Defendants' actions have caused and are continuing to cause Plaintiff irreparable harm.

VI.

CLAIMS FOR RELIEF

COUNT ONE - ADA

86.

Defendants have discriminated and are discriminating against Plaintiff on the basis of her disability in violation of Title II of the ADA, 42 U.S.C. § 12131 *et seq.* and the ADA's implementing regulations at 28 C.F.R. § 35.130.

COUNT TWO - FREEDOM FROM UNDUE RESTRAINT

87.

Defendants have violated and are violating Plaintiff's right to be free from undue restraint, guaranteed to her by the Due Process Clause of the Fourteenth Amendment.

COUNT THREE - RIGHT TO TREATMENT

88.

Defendants have failed and are failing to provide Plaintiff with treatment that is minimally adequate, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT FOUR - REGRESSION

89.

Defendants have failed and are failing to provide Plaintiff with the treatment and training that is necessary to prevent her pre-existing skills from deteriorating as a result of her institutionalization, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT FIVE

TREATMENT RELATED TO  
PURPOSE OF CONFINEMENT

90.

Defendants have failed and are failing to provide Plaintiff with conditions of confinement that are reasonably related to the purpose of her confinement, in violation

of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT SIX  
DEPRIVATION OF STATE-CREATED  
LIBERTY INTEREST

91.

Defendants have failed and are failing to provide Plaintiff with individualized treatment in the least restrictive environment or otherwise provide Plaintiff with proper treatment mandated by state law. Defendants, failure to provide such treatment violates Plaintiff's state-created liberty interest under the Due Process Clause of the Fourteenth Amendment.

VII.  
PRAYER FOR RELIEF

92.

WHEREFORE, Plaintiff requests that this Court:

- A. Assume jurisdiction of this case;
- B. Declare that Defendants' actions and failures to act as described above violate the ADA, the Fourteenth Amendment to the U.S. Constitution, and 42 U.S.C. § 1983;
- C. Preliminarily and permanently enjoin the Defendants from further violating Plaintiff's rights under the ADA, the Fourteenth Amendment, and 42 U.S.C. § 1983 and specifically requiring them to:
  1. Cease discriminating against Plaintiff on the basis of her disability;

2. Provide Plaintiff with appropriate habilitation, training services, and other treatment that comport with professional standards for the treatment of persons suffering from mental retardation and mental illness including, but not limited to, release from GRH-A into a community care residential program;
  3. Require that all habilitation, training services, and other treatment be provided by professionals qualified by education, training, and experience to provide such services;
  4. Provide Plaintiff individualized treatment in the least restrictive environment with the ultimate goal of integrating Plaintiff into the mainstream of society;
  5. Provide Plaintiff minimally adequate treatment to prevent deterioration of her pre-existing skills and that is related to the purpose of her confinement;
  6. Cease unduly restraining Plaintiff's freedom of movement.
- D. Award Plaintiff costs and attorney's fees; and
- E. Award any other relief the Court deems just and equitable.

/s/ Susan C. Jamieson  
SUSAN C. JAMIESON  
Georgia Bar No. 389408  
340 W. Ponce de Leon  
Avenue  
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/s/ Steven D. Caley  
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151 Spring Street  
Atlanta, Georgia  
30303-2097  
(404) 614-3926

Attorneys for Plaintiff

Dated: May 11, 1995.

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

L.C., by JONATHAN ZIMRING as )  
guardian ad litem and next friend, )

Plaintiff, )

v. )

TOMMY OLMSTEAD, Director of )  
the Department of Human )  
Resources; RICHARD FIELDS, )  
Superintendent of Georgia )  
Regional Hospital at Atlanta; and )  
ERNESTINE PITTMAN, Executive )  
Director of the Fulton County )  
Regional Board, all in their official )  
capacities, )

Defendants. )

CIVIL ACTION

FILE NO.

1: 95-CV-1210 MHS

AFFIDAVIT OF M. CECILIA KIMBLE, Ph.D

\* \* \*

28.

The institutional environment, peopled by individuals in crisis and acute psychotic states, is chaotic and complex. Long-term confinement under such conditions for an individual such as L.C., whose ability to comprehend her environment is at an extremely low level, is likely to result in regression or to the development of additional maladaptive modes of behavior.

29.

The development of L.C.'s inappropriate urinary habits and subsequent urinary incontinence while institutionalized is suggestive of the acquisition of maladaptive and regressive behaviors, respectively.

\* \* \*

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Progress Notes  
Patient Identification  
L.C.

Date: 11/4/93

Time: 3:10 pm

Disc.: NSG.

Notes: A - Pt. stable medically & physically, P. Maintain  
highest level of functioning until placement.  
Ahstahes Rn

DATE 11/6/93 TIME 10:30pm

SIGNATURE /s/ SNSTOKES, RN

\* \* \*

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT

Personally appeared, Randy Allen Brazee, the undersigned affiant, who being duly sworn says:

1.

This affidavit is given on the basis of the affiant having personal knowledge pertaining to the above-styled action and the facts stated herein.

2.

I am an adult, competent, and suffer from no disability which affects my capacity to make this affidavit as accurate as possible.

3.

My name is Randy Brazee. I graduated in 1990 from the University of Wisconsin with a BS in social work and psychology.

4.

From August 16, 1993, until January 2, 1995, I was employed by Georgia Regional Hospital - Atlanta (GRH-A), a state psychiatric hospital, as an inpatient social worker and case manager for adults with severe mental illness, a position which included counseling to achieve



treatment goals, development of aftercare plans, intensive case management, and linkage of patients with appropriate community housing and other resources.

## 5.

Since January, 1995, I have been employed by TOPS (Tailored Options for Person-Centered Support) as a case manager.

## 6.

TOPS is a private agency that provides a full range of personalized options for residential, day habilitation, supported employment, and personal assistance services for persons with mental retardation.

## 7.

The unit where I worked at GRH-A is referred to as the "treatment unit." It is a single, large building divided into separate sleeping areas for men, women, or "coed" with a typical patient census of about 65 patients. Most patients stayed for a short time until the acute symptoms of psychiatric illnesses had been stabilized.

## 8.

The treatment unit is not designed or staffed for the habilitation or specialized needs of persons with mental retardation; there is a unit at the hospital where persons with mental retardation reside called the "Developmental Learning Center."

## 9.

When I first began to work at GRH-A in August, 1993, I noted a young female patient, L.C., whose condition remained the same day after day and week after week. She appeared to be stable and simply living at the hospital.

## 10.

When the social worker that had been assigned to L.C. resigned, I asked that she be assigned to my caseload; I was L.C.'s social worker from about November, 1993, until January, 1995, when I left GRH-A to begin my present job.

## 11.

As L.C.'s social worker, I was aware of her physician's opinion that she should not be hospitalized at all, that her psychiatric symptoms had been stabilized, and that she remained hospitalized solely because there were no alternative placement options.

## 12.

Because of the opinion of Dr. Amin and the consensus of L.C.'s treatment team that hospitalization was no longer clinically necessary or appropriate for her, my responsibility was to find alternative placement.

13.

Since L.C.'s psychiatric symptoms were stable, she could function in the community with appropriate day program activities, psychiatric oversight, and residential services designed to meet her individual needs as an adult with mental retardation.

14.

For the first ten months (from November, 1993, through July, 1994), that L.C. was assigned to my case-load, she continued to live in essentially the same situation that I had observed since I began to work on the treatment unit.

15.

During this period, she did very little during the day except sit or walk around the locked "day room" on the ward. The activity that seemed to be the most important to her during this time was smoking cigarettes.

16.

I recall that she participated in activities for just a few hours a day; a pre-vocational program, an evening "hygiene group," and a "communication skills" group.

17.

The pre-vocational program involved routine, repetitive tasks, such as putting caps on bottles. L.C. appeared to enjoy the opportunity to participate in this program,

was successful at most of the assigned tasks, and was highly motivated by the small amount of money that she was able to earn in the program. L.C. would attend the program two to four times a week for about one and one-half hours.

18.

The "communication skills" program was a 4-6 week program to assist hospitalized patients with simple conversational and social skills, such as how to begin and carry on a conversation. The classes were conducted once or twice a week for about an hour.

19.

Because L.C. continued to live in the hospital for years when most patients stayed for just a few weeks, she repeated the "communication skills" workshop over and over again. This repetition was also because L.C. was not able to complete the course. If she had managed to complete it, she would have attended other groups.

20.

L.C. did not learn any new skills in the communication group and often did not understand the classes but she enjoyed being permitted to join the classes.



21.

L.C. attended the evening hygiene group once or twice a week in the evenings for about 30 minutes to an hour.

22.

In addition to these activities, there was a short period when a teacher came to the unit twice a week to teach basic reading, writing, and math skills.

23.

The activities described in the above paragraphs filled only a small portion of L.C.'s days and evenings at the hospital. She very rarely had any visitors and never left the hospital grounds.

24.

As I observed the monotony of L.C.'s life in the mental hospital, I became increasingly frustrated with the complete lack of alternative residential options available to her.

25.

Beginning in December of 1993, I began meeting with a small group of individuals outside the hospital who were concerned about L.C., and had decided to follow an informal planning process called "futures planning" in an effort to find a way through the literal and figurative brick walls between L.C.'s present circumstances and a more

normal, integrated life in a non-institutional environment.

26.

The group has included advocates, L.C.'s family, hospital staff, staff from residential providers, and others; the group has now been meeting for more than eighteen months and L.C. still remains confined at GRH-A.

27.

I assisted another member of the hospital staff, Ms. Sherry Olvey, in the preparation of a letter to the hospital administration on L.C.'s behalf, seeking information about the possibility of allocating funds being spent for L.C. in the hospital toward a community placement. Specifically, the letter suggested that funds used for institutional care could, instead, be used to secure a supervised, federally-funded "medicaid waiver" placement for L.C. in the community.

28.

Ms. Olvey sent the letter to Ms. Elaine King, the Assistant Superintendent for Administration at GRH-A, in September, 1994.

29.

Ms. King responded that L.C. was not eligible for the state's medicaid waiver program because she was a psychiatric inpatient and, therefore, not a current Medicaid

recipient. She stated further that, although it cost the state \$208.00 a day to keep L.C. in the hospital, these were "fixed costs" and the hospital would not use money to support L.C. in the community, even if it cost less "on paper." (copy of letter attached as Exhibit 1)

30.

On September 27, 1994, at my request, Ms. Sue Jamieson, an attorney with Georgia's Protection and Advocacy program, wrote a letter to the hospital superintendent, the state office for mental retardation services, and two regional mental health/mental retardation directors seeking residential services for L.C. (copy of letter attached as Exhibit 2)

31.

On September 28, 1994, after reading the letter from Ms. King to Ms. Olvey, I wrote to Ms. King, further stressing my belief that medicaid waiver funding should be sought for L.C. (copy of letter attached as Exhibit 3)

32.

On December 12, 1994, after learning from Ms. Jamieson that she had received no response to her letter of September 27, I also wrote a letter to the state office of retardation services and to the director of the Fulton County Regional board which provides mental health and mental retardation services through contracts with the state and private providers. This is the entity which

serves residents of Fulton County, L.C.'s county of residence before she was institutionalized. (copy of letter attached as Exhibit 4)

33.

Although I was unable to identify any residential services for L.C., I referred her to a community day program called Community Friendship, Inc. (CFI) which provides a variety of services to mentally disabled persons designed to promote a sense of community and to enhance and develop the abilities of disabled individuals to function as fully as possible in increasingly independent, integrated settings.

34.

L.C. was promptly accepted in June, 1994, into the "social club" and then the "work adjustment" program at CFI.

35.

In August, 1994, I was finally able to arrange transportation for L.C. from the hospital to the CFI program through the public handicapped transportation system.

36.

L.C. has been attending the CFI programs from about 8:30 a.m. until 3:00 p.m. each weekday since August, 1994, to the present.



37.

During the last five months that I worked for GRH-A from August, 1994, to January, 1995, L.C. went each day on the bus to CFI. She became much more cheerful during this period and frequently expressed her great pleasure in the program and in her new friendships with staff and other participants at CFR. She would often talk about things that she did at the program, including the social activities and field trips.

38.

During this period, L.C.'s desire to leave the hospital became more intense and persistent; she was often sad when she had to return to the hospital at the end of the day and very disappointed when the bus did not arrive to transport her to the program in the morning, which happened about once every other week.

39.

I noticed that L.C.'s appearance and her attitude toward herself and others improved after she started to participate in the CFI program away from the hospital.

40.

After beginning the CFI program, L.C. would wait for the bus each morning unaccompanied by staff which resulted in the recognition by the hospital treatment team that she did not need staff supervision at all times.

41.

Since January, 1995, in my present position with TOPS, I have seen other persons with mental retardation with many fewer skills, problem behaviors, and much lower overall functioning levels than L.C. live successful and reasonably normal lives in homes and apartments with individualized supports.

Sworn to and subscribed  
before me this 3rd  
day of May, 1995.

/s/ J Gaston Golson  
NOTARY PUBLIC  
Notary Public, DeKalb County, Georgia  
My Commission Expires October 31, 1997

/s/ Randy A. Brazee  
RANDY A. BRAZEE

---

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

|                                   |                     |
|-----------------------------------|---------------------|
| L.C., by JONATHAN ZIMRING         | *                   |
| as guardian ad litem and next     | * CIVIL ACTION      |
| friend,                           | * FILE              |
|                                   | *                   |
| Plaintiff,                        | * NO. 1:95-CV-1210- |
|                                   | * MHS               |
| vs.                               | *                   |
|                                   | *                   |
| TOMMY OLMSTEAD, Director of       | *                   |
| the Department of Human           | *                   |
| Resources; RICHARD FIELDS,        | *                   |
| Superintendent of Georgia         | *                   |
| Regional Hospital at Atlanta; and | *                   |
| ERNESTINE PITTMAN, Executive      | *                   |
| Director of the Fulton County     | *                   |
| Regional Board; all in their      | *                   |
| official capacities,              | *                   |
|                                   | *                   |
| Defendants.                       | *                   |

ANSWER AND DEFENSES

(Filed Jun. 2, 1995)

COME NOW the Defendants and answer and defend the Complaint as follows:

FIRST DEFENSE

The Complaint fails to state a claim upon which this Court may grant relief.

SECOND DEFENSE

There was no violation of any Constitutional right and no Constitutional deprivation was suffered by Plaintiff.

THIRD DEFENSE

The Defendants answer the numbered paragraphs of the Plaintiff's Complaint as follows:

1.

In response to paragraph 1, Defendants admit based on information and belief that Plaintiff is a 27 year old person with schizophrenia and mental retardation; that Plaintiff was admitted to Georgia Regional Hospital at Atlanta ("GRH-A") on or about May 11, 1992; that Plaintiff is currently living with her mother and receiving services in the community; and that at this time Plaintiff does not require inpatient psychiatric treatment. Defendants admit that GRH-A is a state hospital for the treatment of persons with mental illness and/or mental retardation. All allegations of paragraph 1 not admitted above are denied.

2.

The allegations of paragraph 2 through 5 are denied.

3.

Paragraph 6 sets forth legal conclusions and, hence, requires no answer of these Defendants; to the extent that



an answer is deemed required the allegations of said paragraph are denied.

4.

Without waiving any other defenses, Defendants admit the allegations of paragraph 7 and 8.

5.

In response to paragraph 9, Defendants admit based on information and belief that Plaintiff is 27 years old and has a diagnosis of mental retardation and schizophrenia; that her psychiatric symptoms have been generally stabilized for over two years; that she does not currently require inpatient psychiatric hospitalization; and that she resided in Fulton County prior to admission to GRH-A and that her mother lives in Fulton County. All allegations of paragraph 9 not admitted above are denied.

6.

In response to paragraph 10, Defendants admit that Tommy Olmstead is the Commissioner of the Department of Human Resources ("DHR") with all the duties and responsibilities attendant to that position. Defendants specifically deny that he is responsible for the operation of GRH-A and deny all other allegations of paragraph 10 not admitted above.

7.

In response to paragraph 11, Defendants admit that Richard Fields is the Superintendent of GRH-A, located in DeKalb County, Georgia, with all the duties and responsibilities attendant to that position, and that he is responsible for the administration of GRH-A. Defendants deny all other allegations of paragraph 11.

8.

In response to paragraph 12, Defendants admit that Ernestine Pittman is the Executive Director of the Fulton County Regional Board ("the Board") with all the duties and responsibilities attendant to that position, and deny all other allegations of paragraph 12.

9.

In response to paragraphs 13 through 24, Defendants show that these paragraphs state legal conclusions and arguments, and include partial quotes from various federal and state laws, and they thus require no response from these Defendants; to the extent an answer is deemed required, all allegations of paragraphs 13 through 24 are denied.

10.

In response to paragraph 25, Defendants admit based on information and belief that L.C. is a 27 year old African-American woman with mental retardation and a diagnosis of schizophrenia. Defendants further admit that various records state that L.C. is at times friendly, has a

beautiful smile, that she likes to draw, and that she has hypergraphia, or that she writes on paper excessively. All allegations of paragraph 25 not admitted above are denied.

11.

In response to paragraph 26, to the extent that Plaintiff intends this allegation to be a legal conclusion, no response if required of Defendants; without admitting to any legal conclusions, Defendants admit based on information and belief that Plaintiff has mental disabilities and is to some extent mentally disabled.

12.

In response to allegations of paragraph 27, Defendants admit based on information and belief records that L.C. has consistently been diagnosed with mild or moderate mental retardation, that she has only very elementary ability to read and write and that she has some ability to understand abstract concepts. All allegations of paragraph 27 not admitted above are denied.

13.

In response to paragraph 28, Defendants admit that GRH-A is a facility for the treatment of persons with mental illness, mental retardation and substance abuse problems and that it is owned and operated by the State and its agencies. Defendants further admit based on information and belief that L.C. has lived most of her life

since age 14 at GRH-A and other institutions. All allegations of paragraph 28 not admitted above are denied.

14.

In response to paragraph 29, Defendants admit the allegations of this paragraph, showing, however, that GRH-A also treats persons with mental retardation and has programs in addition to those described in the Complaint, including programs for persons with mental retardation.

15.

In response to paragraph 30, Defendants admit based on information and belief that L.C. resided at GRH-A for more than three years and deny all other allegations of paragraph 30.

16.

Defendants admit the allegations of paragraph 31, except that between 30 to 60 patients reside in each building, not in each unit as stated in this paragraph.

17.

Defendants admit the allegations of paragraph 32, except that the average number of patients in the building, not unit as stated in this paragraph, is 60, not 65.



50

18.

In response to paragraph 33, Defendants admit based on information and belief that in 1991 L.C. was placed in a community program for persons with mental retardation and that Project Rescue, a non-profit organization, was involved. All other allegations of paragraph 33 are denied.

19.

In response to paragraph 34, Defendants admit based on information and belief that L.C. was maintained in the community for about one year, with several shortterm admissions back to GRH-A. All other allegations of paragraph 34 are denied.

20.

In response to paragraph 35, Defendants show that an admission assessment dated May 11, 1992, states that L.C. was violent, hearing voices, wanted to return to GRH-A, was aggressive toward others, and attempted to harm a staff person with a knife. With regard to the remaining allegations of paragraph 35, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 35 of the Complaint and hence can neither admit nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

51

22.

The allegations of paragraph 36 are admitted.

23.

In response to paragraph 37, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 37 and hence can neither admit nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

24.

The allegations of paragraph 38 are denied based on information and belief.

25.

In response to paragraph 39, Defendants admit that the records include a treatment plan developed by GRH-A at the time of her hospitalization which included the stabilization of her mental illness. All other allegations of paragraph 39 are denied based on information and belief.

26.

In response to paragraph 40, based on information and belief Defendants deny the allegations as written, showing that once L.C.'s condition stabilized, a "partial hospitalization" program including community based day treatment services with hospitalization at night was

developed for L.C. All other allegations of paragraph 40 are denied based on information and belief.

27.

The allegations of paragraph 41 are denied.

28.

In response to paragraph 42, Defendants admit based on information and belief that in or about February 1993 a social worker sought mental retardation services including placement for L.C. All other allegations of paragraph 42 are denied based on information and belief.

29.

In response to paragraph 43, Defendants admit that the allegations quote parts of statements from a March 1993 Doctors Progress Note; in addition to the parts quoted by the Complaint, the doctor's note also states that L.C. had done better but remained delusional on neuroleptic medication.

30.

In response to the allegations of paragraphs 44 and 45, Defendants admit that these paragraphs quote parts of the record at GRH-A.

31.

In response to paragraph 46, Defendants admit that the allegations quote from part of an August 9, 1993, doctor's progress note, but show that the part quoted is so incomplete as to mischaracterize the note; Defendants show that in addition to L.C.'s problems with hygiene quoted in the complaint, the note also stated that L.C.'s urinating in the closet was one of L.C.'s problems.

32.

The allegations of paragraph 47 are admitted based on information and belief.

33.

The allegations of paragraphs 48 and 49 are denied.

34.

In response to the allegations of paragraph 50, Defendants deny that Plaintiff is confined at GRH-A. The remaining allegations are admitted based on information and belief, but Defendants show that GRH-A is not required to design an individualized habilitation program for L.C.

35.

The allegations of paragraph 51 are denied.



54

36.

The allegations of paragraph 52 are admitted as they apply to the time that L.C. was at GRH-A, but Defendants show that L.C. was appropriately placed and received adequate treatment at GRH-A.

37.

The allegations of paragraph 53 are denied based on information and belief.

38.

The allegations of paragraphs 54 and 55 are denied.

39.

In response to paragraph 56, the allegations of sentences 1 and 2 are denied based on information and belief. The allegations of sentence 3 are admitted, but Defendants show that L.C.'s treatment plan included personal hygiene education and training.

40.

In response to paragraph 57, Defendants deny based on information and belief that hospital staff often control L.C. with the administration of sedatives or psychotropic drugs when she is loud and disruptive. With regard to the remaining allegations of paragraph 57, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 57 of the Complaint and hence can neither admit

55

nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

41.

The allegations of paragraphs 58 and 59 are denied based on information and belief.

42.

The allegations of paragraphs 60 through 65 are denied.

43.

The allegations of sentence 1 of paragraph 66 are admitted. The allegations of sentence 2 of paragraph 66 are denied.

44.

The allegations of paragraphs 67 through 70 are denied.

45.

In response to paragraph 71, Defendants admit that there are various private and public providers in Georgia of supervised, community-based residential programs for persons with mental retardation. Defendants are without knowledge or information sufficient to form an opinion of the truth of the remaining allegations of paragraph 71 and hence can neither admit nor deny same; to the extent

56

a response is deemed required, said allegations are denied.

46.

The allegations of paragraph 72 are admitted based on information and belief.

47.

In response to paragraph 73, Defendants admit based on information and belief that L.C. is both mentally retarded and mentally ill and deny all other allegations of paragraph 73.

48.

The allegations of paragraph 74 are denied.

49.

In response to the allegations of paragraph 75, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 75 of the Complaint and hence can neither admit nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

50.

In response to paragraph 76, the allegations are too vague and ambiguous as to be capable of a response; to

57

the extent a response is deemed required, said allegations are denied.

51.

In response to paragraph 77, Defendants admit based on information and belief that L.C. received approximately the amounts listed in said paragraph.

52.

The allegations of paragraph 78 and 79 are admitted, except that Defendants show that state law requires the application of portions of the lump sum and monthly benefits to the cost of her care.

53.

In response to paragraph 80, Defendants admit based on information and belief that \$6740.80 of the social security benefits were applied toward the cost of her care at GRH-A; that approximately \$700.00 was spent on personal items needed by L.C.; that she has approximately \$2000.00 in a spending account; and that she has \$5000 in a burial account. All other allegations of paragraph 80 are denied.

54.

In response to paragraph 81, Defendants admit based on information and belief that GRH-A failed to submit a claim for available medicare insurance coverage on L.C.'s



behalf until recently. All other allegations of paragraph 81 are denied.

55.

In response to the allegations of paragraph 82, Defendants admit that L.C. had a right to a hearing but specifically deny that essentially all her funds were applied to the cost of her care.

56.

In response to paragraph 83, Defendants admit based on information and belief that notices regarding the procedures for requesting hearings were received by GRH-A. In regard to the remaining allegations of paragraph 83, these Defendants are without knowledge or information sufficient to form a belief as to the truth of the allegations in paragraph 83 of the Complaint and hence can neither admit nor deny same; to the extent that an answer is deemed required, the allegations of said paragraph are denied.

57.

In response to paragraph 84, Paragraph 84 of the Complaint sets forth legal conclusions and, hence, require no answer of these Defendants; to the extent that an answer is deemed required the allegations of said paragraph are denied.

58.

The allegations of paragraphs 85-91 are denied.

59.

In response to paragraph 92, Plaintiff merely states the relief she requests and said paragraph requires no response of Defendants; to the extent a response is deemed required, all allegations of paragraph 92 are denied.

60.

Any allegations of the complaint not admitted, denied or otherwise responded to above are denied.

WHEREFORE, having fully responded to the allegations of the complaint, Defendants pray that the complaint be dismissed, that all costs be taxed against Plaintiff, and for such other relief as the Court deems just.

Respectfully submitted,

MICHAEL J. BOWERS 071650  
Attorney General

/s/ William C. Joy  
WILLIAM C. JOY  
by Pw/Rem. 405500  
Senior Assistant Attorney  
General

(Signatures continued on next page)

/s/ Patricia Downing  
 PATRICIA DOWNING 228350  
 Senior Assistant Attorney  
 General

PLEASE ADDRESS ALL  
 COMMUNICATIONS TO:

PATRICIA DOWNING  
 Senior Assistant Attorney General  
 40 Capitol Square, S.W.  
 Atlanta, Georgia 30334-1300  
 Telephone: (404) 656-3338

#### CERTIFICATE OF SERVICE

I do hereby certify that I have this day served the within and foregoing ANSWER AND DEFENSES, prior to filing the same, by depositing a copy thereof, postage prepaid, in the United States Mail, properly addressed upon:

Steven Caley  
 Atlanta Legal Aid  
 151 Spring Street  
 Atlanta, Georgia 30303-2097

Sue Jamieson  
 Atlanta Legal Aid  
 340 W. Ponce de Leon Avenue  
 Decatur, Georgia 30030

This 1st day of June, 1995.

/s/ Patricia Downing  
 PATRICIA DOWNING

#### IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA ATLANTA DIVISION

L.C., by JONATHAN ZIMRING )  
 as guardian ad litem and next )  
 friend, )

Plaintiff, )

v. )

TOMMY OLMSTEAD, Director of )  
 the Department of Human )  
 Resources; RICHARD FIELDS, )  
 Superintendent of Georgia )  
 Regional Hospital at Atlanta; and )  
 ERNESTINE PITTMAN, Executive )  
 Director of the Fulton County )  
 Regional Board, all in their )  
 official capacities, )

Defendants. )

CIVIL ACTION

FILE NO.

1: 95-CV-1210

#### INTERVENOR'S COMPLAINT

#### PRELIMINARY STATEMENT

1.

L.C. is mentally retarded and filed this case after three years in a state mental hospital, confinement that continued contrary to the judgment of her treatment professionals that she needed alternative community placement. L.C.'s independent psychologist concurred with other psychological evaluations in past years that she should be viewed from a developmental rather than a psychiatric perspective and that prolonged psychiatric



institutionalization has been inappropriate and detrimental. After spending more than half of the past 14 years in mental hospitals and shortly after the case was filed, L.C. was placed on "trial visit" with her mother without adequate discharge planning or community services. There are no identified community-based alternatives to interrupt the 14-year pattern of inappropriate and prolonged psychiatric hospitalizations which occur when L.C.'s behavior becomes difficult to manage.

2.

Intervenor, E.W., resides in the same locked psychiatric ward where L.C. resided until her "trial visit." Like L.C., she is mentally retarded and needs habilitation to address her needs as a mentally retarded adult. E.W. has been confined there since October, 1994, although she does not require inpatient psychiatric care and could be served more appropriately in a structured and supervised community setting designed to serve mentally retarded persons. Her history of psychiatric confinements stretches back for years and includes a series of discharges to inappropriate and inadequate boarding homes. Recently, the hospital had planned to discharge E.W. to a homeless shelter but declined after E.W.'s attorney intervened on her behalf.

#### JURISDICTION

3.

Jurisdiction is conferred on this Court by 28 U.S.C. §§ 1331 and 1343 and 42 U.S.C. § 12133 in that this is an

action arising under the Americans with Disabilities Act, the United States Constitution, and 42 U.S.C. § 1983. Declaratory and injunctive relief is authorized by 28 U.S.C. §§ 2210 and 2202.

4.

Venue is proper under 28 U.S.C. § 1391.

#### PARTIES

5.

Plaintiff, E.W., is a 43-year-old mentally retarded woman who also has been diagnosed with a variety of mental disorders. She is currently confined in a psychiatric ward at Georgia Regional Hospital at Atlanta ("GRH-A") where she has been confined more than 30 times since 1975.

6.

Defendant Tommy Olmstead is the Commissioner of the Department of Human Resources ("DHR") and is responsible for the operation of GRH-A, for the protection of the rights of persons confined to GRH-A, and for the overall provision of services to persons suffering from mental retardation and mental illness in the State of Georgia.

7.

Defendant Richard Fields is the Superintendent of GRH-A, located in DeKalb County, Georgia. As such, he

is responsible for the operation of GRH-A, for the treatment of persons confined to GRH-A, and for the protection of rights of persons confined to GRH-A.

8.

Defendant Ernestine Pittman is the Executive Director of the Fulton County Regional Board (the "Board") and is responsible for the provision of mental health and mental retardation services, including community care and placement, for all residents of Fulton County.

#### FACTS

9.

E.W.'s most recent series of hospitalizations at GRH-A began in October, 1994. Since that date, she has been discharged to at least five different boarding homes for short periods of time and re-admitted because of behavior problems, serious side-effects to prescribed medication, suicidal behavior, and misconduct on the part of one of the boarding home operators. The last discharge to a personal care home on February 7, 1995, lasted for less than a day before she was re-admitted to the hospital because of verbal outbursts.

10.

In March, 1995, the hospital was planning to release her to a homeless shelter but agreed to seek a more appropriate placement after intervention by E.W.'s attorney.

11.

The decision to place E.W. in a shelter was based, in part, on the opinion of her physician that the mental hospital was an "overprotective" environment but the record does not reflect an effort to secure appropriate less "protective" community services designed to provide her with habilitation, structure, supervision, or psychiatric oversight.

12.

In April, 1995, E.W. secured an independent psychological evaluation which indicated that she had severe deficits in the areas of social skills and adaptive functioning and needed community placement in a supervised and structured residential setting designed for individuals with mental retardation and behavioral/emotional deficits; the evaluation also recommended participation in a sheltered workshop program and noted that E.W.'s many hospitalizations are due to possible inappropriate placements.

13.

On April 18th, 1995, a staffing was held to discuss E.W.'s placement but, upon information and belief, no alternative community services have been identified and E.W.'s confinement at GRH-A continues on an indefinite basis due to a perceived lack of community placements.



14.

Since the decision to discharge her to a homeless shelter was rescinded in March, 1995, E.W. experienced a severe medication reaction and has been hospitalized in a medical facility on an emergency basis for dehydration, indicating that discharge to a shelter, in addition to being clearly inappropriate, might have put her at serious medical risk.

15.

The GRH-A treatment unit where E.W. is confined is designed to provide short-term treatment to mentally ill persons in need of acute care and is not designed or staffed to provide the training, habilitation, education, or vocational skills, and behavioral management services that E.W. needs as a mentally retarded adult with behavior problems.

16.

E.W. is not receiving minimally adequate treatment or habilitation consistent with qualified professional judgment.

17.

In order for E.W. to receive minimally adequate treatment and habilitation to address her needs, including the problems resulting from years of inappropriate psychiatric institutionalization and lack of habilitation, she requires appropriate, community-based services.

18.

E.W. is institutionalized because of her disabilities but could be served in a more appropriate, integrated, community setting.

19.

During E.W.'s confinement at GRH-A, she has been secluded, placed in physical restraints, and administered sedative shots on a number of occasions without the development of a behavior management plan to enable E.W. to learn appropriate behaviors and avoid unnecessary or excessive use of restraints.

20.

Because E.W. is in a mental hospital, the policies, standards, and regulations applicable to the appropriate habilitation of mentally retarded persons in state, federal, and other publicly-funded programs, such as those that govern the use of restraint, seclusion, medication, and the development and implementation of habilitation plans, have not been followed by her treating professionals at GRH-A.

21.

Upon information and belief, none of the professionals on E.W.'s treatment team at GRH-A are qualified mental retardation professionals with experience or training in the habilitation of mentally retarded persons nor has E.W. been evaluated by any such professional on the

hospital staff until the intervention of her attorney referred to in Paragraph 10.

22.

The record also reveals that the hospital staff was and is without basic information regarding both the capacity of mentally retarded persons to live in the community with proper support and the capability of mental retardation community programs to deal with E.W.'s behavioral deficits.

23.

Minimal habilitation for E.W. would consist of specialized programs, training, and behavior management programs designed by mental retardation professionals to meet her individual needs.

24.

The minimally adequate setting for E.W.'s long-term habilitation is placement in the community.

25.

The state, through its county, regional, and contracted private providers operates a supervised, community-based residential program for persons with mental retardation. The cost of placement in such a program is substantially less expensive than the cost of institutional care.

26.

There are existing vocational, habilitative, social, and residential programs in the community operated fully or in part by the Defendants with the necessary experience, qualified staff, and the appropriate support and supervision to provide E.W. with the minimal habilitation that she needs in a much more integrated setting than her present institutional placement.

27.

At all times relevant to this Complaint, Defendants have acted under color of state law.

28.

Defendants' actions have caused and are continuing to cause Plaintiff irreparable harm.

#### CLAIMS FOR RELIEF

#### COUNT ONE - ADA

29.

Defendants have discriminated and are discriminating against Plaintiff on the basis of her disability in violation of Title II of the ADA, 42 U.S.C. § 12131 *et seq.* and the ADA's implementing regulations at 28 C.F.R. § 35.130.



COUNT TWO - FREEDOM FROM UNDUE RESTRAINT

30.

Defendants have violated and are violating Plaintiff's right to be free from undue restraint, guaranteed to her by the Due Process Clause of the Fourteenth Amendment.

COUNT THREE - RIGHT TO TREATMENT

31.

Defendants have failed and are failing to provide Plaintiff with treatment and discharge planning that is minimally adequate, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT FOUR - REGRESSION

32.

Defendants have failed and are failing to provide Plaintiff with the treatment and training that is necessary to prevent her pre-existing skills from deteriorating as a result of her institutionalization, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT FIVE

33.

TREATMENT RELATED TO  
PURPOSE OF CONFINEMENT

Defendants have failed and are failing to provide Plaintiff with conditions of confinement that are reasonably related to the purpose of her confinement, in violation of her rights under the Due Process Clause of the Fourteenth Amendment.

COUNT SIX

34.

DEPRIVATION OF STATE-CREATED  
LIBERTY INTEREST

Defendants have failed and are failing to provide Plaintiff with individualized treatment in the least restrictive environment or otherwise provide Plaintiff with appropriate discharge planning or proper treatment mandated by state law. Defendants' failure to provide such treatment mandated by Plaintiff's state-created liberty interest under the Due Process Clause of the Fourteenth Amendment.

PRAYER FOR RELIEF

35.

WHEREFORE, the Plaintiff-Intervenor prays that this Court:

- A. Assume jurisdiction of this case;
- B. Declare that Defendants' actions and failures to act as described above violate the ADA, the Fourteenth Amendment to the U.S. Constitution, and 42 U.S.C. § 1983;
- C. Preliminarily and permanently enjoin the Defendants from further violation Plaintiff-Intervenor's rights under the ADA, the Fourteenth Amendment, and 42 U.S.C. § 1983 and specifically requiring them to:
  1. Cease discriminating against Plaintiff on the basis of her disability;
  2. Provide Plaintiff-Intervenor with appropriate discharge planning, habilitation, training services and other treatment that comports with professional standards for the treatment of persons with mental retardation and mental illness including, but not limited to, release from GRH-A into a community-based residential program;
  3. Require that all discharge planning, habilitation, training services, and other treatment be provided by professionals qualified by education, training, and experience to provide such services;

4. Provide Plaintiff-Intervenor with individualized treatment in the least restrictive environment with the ultimate goal of integrating Plaintiff into the mainstream of society;
5. Provide Plaintiff-Intervenor minimally adequate treatment to prevent deterioration of her preexisting skills and that is related to the purpose of her confinement;
6. Cease unduly restraining Plaintiff's freedom of movement.
- D. Award Plaintiff-Intervenor costs and attorney's fees and
- E. Award any other relief the Court deems just and equitable.

/s/  
 SUSAN C. JAMIESON  
 Georgia Bar No. 389408  
 340 West Ponce de Leon  
 Avenue  
 Decatur, Georgia 30030  
 (404) 377-0701

/s/  
 STEVEN D. CALEY  
 Georgia Bar. No. 102866  
 151 Spring Street  
 Atlanta, Georgia 30303  
 (404) 614-3926

ATTORNEYS FOR PLAINTIFF  
 AND PLAINTIFF-INTERVENOR



IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

|                                   |   |               |
|-----------------------------------|---|---------------|
| L.C., by JONATHAN ZIMRING         | ) |               |
| as guardian ad litem and next     | ) |               |
| friend,                           | ) |               |
| Plaintiff,                        | ) | CIVIL ACTION  |
| v.                                | ) | FILE NO.      |
|                                   | ) | 1: 95-CV-1210 |
| TOMMY OLMSTEAD, Director of       | ) |               |
| the Department of Human           | ) |               |
| Resources; RICHARD FIELDS,        | ) |               |
| Superintendent of Georgia         | ) |               |
| Regional Hospital at Atlanta; and | ) |               |
| ERNESTINE PITTMAN, Executive      | ) |               |
| Director of the Fulton County     | ) |               |
| Regional Board, all in their      | ) |               |
| official capacities,              | ) |               |
| Defendants.                       | ) |               |

CERTIFICATE OF SERVICE

This is to certify that I have this day served the opposing party in the foregoing matter with a copy of the Intervenor's Complaint by depositing in the United States mail a copy of same in a properly addressed envelope with adequate postage thereon to:

Patricia Downing  
Sr. Asst. Attorney General  
40 Capitol Square  
Atlanta, Georgia 30334

This 16th day of June, 1995.

/s/ Susan C. Jamieson  
SUSAN C. JAMIESON

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

CONSENT ORDER

\* \* \*

2. Defendants shall discharge Plaintiff from Georgia Regional Hospital at Atlanta to the Brook Run facility in Atlanta, a facility for persons with mental retardation, effective July 27, 1995, on a temporary basis pending the completion of the assessments listed above and the development of a final plan regarding appropriate community services for Plaintiff, including placement.

\* \* \*

**IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION**

L.C., BY JONATHAN ZIMRING, \*  
as guardian ad litem \*  
and next friend, \*

Plaintiff, \*

v. \*

TOMMY OLMSTEAD, \*  
Commissioner of the Department \*  
of Human Resources; RICHARD \*  
FIELDS, Superintendent of \*  
Georgia Regional Hospital at \*  
Atlanta; and ERNESTINE \*  
PITTMAN, Executive Director of \*  
the Fulton County Regional \*  
Board, all in their official \*  
capacities, \*

Civil Action No. \*  
1:95-CV-1210- \*  
MHS \*

**DEFENDANTS' RESPONSE TO  
INTERVENOR'S COMPLAINT**

(Filed Feb. 20, 1996)

**COME NOW** Defendants and answer and defend the  
Intervenor's Complaint as follows:

**FIRST DEFENSE**

The Complaint fails to state a claim upon which relief  
may be granted.

**SECOND DEFENSE**

There was no violation of any constitutional right  
and no constitutional deprivation was suffered by Inter-  
venor.

**THIRD DEFENSE**

Defendants answer the numbered paragraphs of the  
Intervenor's Complaint as follows:

1.

Defendants deny paragraph 1 of Intervenor's Com-  
plaint as written showing that L.C. is mentally ill and  
mentally retarded; that she has been treated for many  
years in a state mental hospital and at the time this  
lawsuit was filed she had been receiving treatment at  
Georgia Regional Hospital at Atlanta ("GRH-A") for  
three years. Defendants further admit that L.C. was  
referred for a psychological evaluation for alternate  
placement by her attorney, Susan M. Jamieson, and that  
the evaluation stated that it would be more valuable to  
view her from a developmental rather than a psychiatric  
perspective. Defendants further admit based on informa-  
tion and belief that L.C. has lived most of her life since  
age 14 at GRH-A and other institutions, including a brief  
incarceration for attempting bodily harm against her sis-  
ter; and that before this case was filed, L.C. was sched-  
uled for a "trial visit" with her mother and that the trial  
visit began shortly after the case was filed. All allegations  
of paragraph 1 not admitted above are hereby denied.



## 2.

Defendants deny paragraph 2 as written, showing that Intervenor resides in the same psychiatric treatment unit where L.C. resided prior to her trial visit, and that the unit is locked; that Intervenor is mentally ill and mentally retarded and that she may benefit from an individualized habilitation program to address her needs as a mentally retarded and mentally ill adult; that E.W. has been receiving treatment at GRH-A since December 20, 1994, not October, 1994 as stated in the Complaint; that based on information and belief, E.W. was originally admitted for hospitalization at GRH-A on March 7, 1975 and that she has been discharged at times to personal care homes; that in March 1995 when E.W. requested discharge, GRH-A planned to discharge her, was unable to locate a personal care home which would take her back, and E.W. had no plans for placement other than a homeless shelter, but that after E.W.'s attorney, Susan M. Jamieson, and others intervened, E.W. agreed to voluntarily stay at GRH-A, and GRH-A agreed to continue her voluntary treatment at the hospital. All allegations of paragraph 2 not admitted above are hereby denied.

## 3.

In response to paragraph 3, this paragraph merely states legal conclusions and hence no response is required of these Defendants. To the extent that a response is deemed required, said allegations are denied.

## 4.

The allegations of paragraph 4 are admitted.

## 5.

In response to paragraph 5, Defendants admit that E.W. is a 44-year old woman who has been diagnosed during this admission as having mild to moderate mental retardation, border-line personality disorder, and psychotic disorder NOS ("not otherwise specified"); that she is currently being treated in a psychiatric unit at GRH-A and that she has had over thirty (30) admissions since 1975. All allegations of paragraph 5 not admitted above are denied.

## 6.

In response to paragraph 6, Defendants admit that Tommy Olmstead is the Commissioner of the Georgia Department of Human Resources ("DHR") with all the duties and responsibilities attendant to that position. Defendants specifically deny that he is responsible for the operation of GRH-A and deny all other allegations of paragraph 6 not admitted above.

## 7.

In response to paragraph 7, Defendants admit that Richard Fields is Superintendent of GRH-A, located in DeKalb County, Georgia, with all the duties and responsibilities attendant to that position, and that he is responsible for the administration of GRH-A. Defendants deny all other allegations of paragraph 7.

## 8.

In response to paragraph 8, Defendants admit that Ernestine Pittman is the Executive Director of the Fulton County Regional Board ("the Board") with all the statutory duties and responsibilities attendant to that position, and deny all other allegations of paragraph 8.

## 9.

In response to paragraph 9, Defendants admit that E.W. has been admitted to GRH-A three times since October 8, 1994, and that her admissions since October 8, 1994 have been because of behavior problems, side effects to prescribed medication, suicidal behavior, and misconduct on the part of one of the personal care home operators; that she was placed on a trial visit in a personal care home on February 7, 1995 and that she was returned to GRH-A within one day because of her verbal outbursts. All other allegations of paragraph 9 not admitted above are denied.

## 10.

Defendants deny paragraph 10 as written, showing that in March 1995, when E.W. requested discharge, GRH-A planned to discharge her, was unable to locate a personal care home which would take her back, and E.W. had no plans for placement other than a homeless shelter, but that after E.W.'s attorney, Susan M. Jamieson, and others intervened, E.W. agreed to voluntarily stay at GRH-A, and GRH-A agreed to continue her voluntary

treatment at the hospital. All allegations of paragraph 10 not admitted above are hereby denied.

## 11.

The allegations of paragraph 11 are denied.

## 12.

In response to paragraph 12, Defendants admit that in April, 1995, E.W. was referred for a psychological evaluation by her attorney, Susan M. Jamieson. Defendants deny that the Complaint accurately reflects the conclusion of the evaluation, and show that the evaluation indicated that E.W. had severe deficits in the area of adaptive functioning, and profound (not severe as stated in the Complaint) deficits in the area of social skills. Defendants show that the evaluation did not state that she needed a community placement as stated in the Complaint; but rather stated that "if she is discharged from Georgia Regional she needs to have a highly structured residential home appropriate for an individual with mental retardation and behavioral/emotional deficits." Defendants admit that the evaluation also stated that her attorney, Ms. Jamieson, expressed the opinion that E.W. had been in inappropriate placements, and it recommended participation in a sheltered workshop program appropriate for a mentally retarded individual who has been institutionalized many times due to possible inappropriate placements. All allegations of paragraph 12 not admitted above are denied.



## 13.

In response to paragraph 13, Defendants admit that on April 18, 1995, a staffing was held to address Sue Jamieson's Complaint and concerns regarding E.W.'s placement and that Sue Jamieson attend the staffing. All allegations of paragraph 13 not admitted above are denied.

## 14.

In response to paragraph 14, Defendants admit that in May, 1995, E.W. was hospitalized in a medical hospital for dehydration to her refusing to eat or drink. All other allegations of paragraph 14 are denied.

## 15.

Defendants deny paragraph 15 as written, showing that the GRH-A treatment unit where E.W. is treated is designed to provide short-term and long-term treatment to mentally ill persons and that GRH-A provides all the training, rehabilitation, education, vocational skills, and behavioral management services that E.W. may need at different times, although E.W.'s particular unit may not always provide these services. Any allegations of paragraph 15 not admitted above are denied.

## 16.

The allegations of paragraph 16 are denied.

## 17.

The allegations of paragraph 17 are denied.

## 18.

In response to paragraph 18, Defendants admit that E.W. is institutionalized because of her disabilities and deny all other allegations of paragraph 18.

## 19.

Defendants deny paragraph 19 as written, showing that during E.W.'s treatment at GRH-A, it has been necessary to place her in seclusion or physical restraints, or to administer sedative shots at different times, even though an individualized treatment plan had been developed to enable E.W. to develop appropriate behaviors and avoid unnecessary or excessive use of restraints. Defendants further show that during part of her hospitalization a formal behavior management plan had not been developed but show that one was not required. All other allegations of paragraph 19 are denied.

## 20.

Defendants deny the allegations of paragraph 20 as written, showing that the policies, standards and regulations applicable to the treatment of persons in a psychiatric facility are different than the policies, standards, and regulations applicable to persons in an Intermediate Care Facility For the Mentally Retarded ("ICF-MR"), including

those that govern the use of restraint, seclusion, medication, and the development and implementation of rehabilitation plans; therefore, the policies, standards, and regulations applicable to an ICF-MR facility do not apply to E.W., because she is being treated on a psychiatric unit. All allegations of paragraph 20 not admitted above are denied.

## 21.

The allegations of paragraph 21 are denied.

## 22.

The allegations of paragraph 22 are denied.

## 23.

The allegations of paragraph 23 are denied.

## 24.

The allegations of paragraph 24 are denied.

## 25.

In response to paragraph 25, Defendants admit that the State's regional boards contract with community service boards and/or with private providers to provide supervised, community-based residential programs for some persons with mental retardation. Defendants further admit that generally the cost of placement in such a program is less expensive than the cost of institutional

care, but this varies with the individual needs of the consumer. All other allegations of paragraph 25 are denied.

## 26.

The allegations of paragraph 26 are denied.

## 27.

Paragraph 27 merely states a legal conclusion and requires no response of Defendants; to the extent a response is deemed required, the allegations of paragraph 27 are denied.

## 28.

The allegations of paragraphs 28 through 34 are denied.

## 29.

In response to paragraph 35, this paragraph merely states the relief desired by Plaintiff Intervenor and requires no response of these Defendants; to the extent a response is deemed required, any allegations of paragraph 35 are denied.

## 30.

Any allegations not admitted, denied or otherwise responded to above are hereby denied.



**WHEREFORE**, having fully responded to the allegations of Plaintiff Intervenor's Complaint, Defendants pray that the Complaint be dismissed, that costs be taxed against Plaintiff Intervenor, and for such other relief as the Court deems just.

Respectfully submitted,

MICHAEL J. BOWERS 071650  
Attorney General

GEORGE P. SHINGLER 642850  
Deputy Attorney General

/s/ W. F. Amideo  
WILLIAM F. AMIDEO 016010  
Senior Assistant Attorney  
General

/s/ Patricia Downing  
PATRICIA DOWNING 228350  
Senior Assistant Attorney  
General

PLEASE ADDRESS ALL  
COMMUNICATIONS TO:

PATRICIA DOWNING  
Senior Assistant Attorney General  
40 Capital Square, S.W.  
Atlanta, GA 30334-1300  
Telephone: (404) 656-5161 ..

# **CERTIFICATE OF SERVICE**

I do hereby certify that I have this day served the within and foregoing **DEFENDANTS' RESPONSE TO INTERVENOR'S COMPLAINT**, prior to filing the same, by depositing a copy thereof, postage prepaid, in the United States Mail, properly addressed upon:

Susan C. Jamieson  
ATLANTA LEGAL AID  
SOCIETY, INC.  
DeKalb/Gwinnett Office  
340 West Ponce de Leon Avenue  
Decatur, GA 30030

Sylvia B. Caley  
ATLANTA LEGAL AID  
SOCIETY, INC.  
151 Spring Street  
Atlanta, GA 30303

Steven D. Caley  
ATLANTA LEGAL AID  
SOCIETY, INC.  
151 Spring Street  
Atlanta, GA 30303

This 19th day of February, 1996.

/s/ Patricia Downing  
PATRICIA DOWNING  
Senior Assistant  
Attorney General

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In the United States District Court  
For the Northern District of Georgia  
Atlanta Division

[Caption Omitted In Printing]  
Plaintiffs' Statement Of Material Facts

\* \* \*

21.

On March 20, 1995, Attorney Susan C. Jamieson filed a formal administrative complaint with Dr. Richard Fields asserting that the plan to discharge E.W. to a homeless shelter was inappropriate. Exh. 4.

22.

Following the complaint by Susan Jamieson, E.W. was not discharged. Patel II dep. exh. 2, p. 2 introduced at p. 28, l. 3-6; Parrish dep. p. 95, l. 1-11.

\* \* \*

54.

A suitable placement for E.W. could be a group home for upper level mentally retarded with or without some degree of mental illness, with strong staffing and with available day programs, including vocational rehabilitation, and treatment activities if necessary. DeBacher dep. p. 27, l. 11-16.

\* \* \*

57.

Dr. Patel felt that E.W. could have been treated as an outpatient in March 1995. Her behavior problems are long term problems and could be addressed in the community.

\* \* \*

70.

The Mental Retardation Waiver Program is a program providing funding for individually designed community placements and necessary community services. The Mental Retardation Waiver Program provides a flexible funding mechanism to meet individuals' needs for community services. The funding source is Medicaid so that the State contributes approximately 40% of the funds and the federal government contributes the remaining 60%. The purpose of the Mental Retardation Waiver Program is to improve the lives of individuals by providing them with community services while saving the state money by avoiding costly institutional care.

\* \* \*

81.

L.C.'s needs can be met by placing her in an appropriate community residential setting with adequate supports.

\* \* \*



The treatment unit at GRH-A, where L.C. was confined from May, 1992, until May, 1995, is a single, large building divided into separate sleeping areas for men, women, or co-ed with a typical patient census of about 65 patients. Most patients stay for a short time until the acute symptoms of psychiatric illnesses have been stabilized.

\* \* \*

L.C. was re-institutionalized at Brook Run, a mental retardation institution, even though she did not need institutional care. Patel I dep. p. 123, l. 5-21, p. 9-15.

L.C. was placed at Brook Run because there was no other alternative. Patel I dep. p. 123, l. 14-17.

\* \* \*

During the three years that [L.C.] was confined at GRH-A from May 1992 until May 1995, no individual habilitation program was designed or implemented for her by qualified mental retardation professionals.

\* \* \*

The institutional environment at GRH-A, peopled by individuals in crisis and acute psychotic states, is chaotic and complex.

\* \* \*

L.C.'s physician at GRH-A, Dr. Ramesh Amin, notes that placement is a problem for L.C. in August of 1993. Dr. Amin felt that a community placement for L.C. would have needed 24 hour supervision, day treatment, and vocational rehabilitation. By November 1993 L.C.'s treatment team was looking for a community placement for her. GRH-A records, 8/9/93, progress notes, Exh. 53; Amin dep. p. 61, l. 8-19, p. 60, l. 7-13.

\* \* \*

L.C.'s social worker at GRH-A in December, 1993, noted that "placement is a possibility with the right services linked up." GRH-A record, 12/1/93, progress notes, Exh. 55.

L.C. could have been placed in the community no later than 1993 if the focus of treatment had been on her developmental disabilities and the pharmacologic approach had been different. Elliott II dep. p. 81, l. 15-21.

\* \* \*

160.

Mr. Brazee, L.C.'s social worker, attempted to find a placement for her through the Mental Retardation Waiver Program. Together with Ms. Sherry Olvey, Mr. Brazee sent a letter to Elaine King, the assistant superintendent for administration at GRH-A in September 1994. Brazee Aff. ¶¶ 27, 28, Exh. 29.

\* \* \*

164.

Capable providers exist to treat person such as E.W. in the community.

165.

Community Placements are available if there is money to fund them.

\* \* \*

170.

When the Georgia legislature passed H.B. 100, O.C.G.A. §37-2-5.1(c), it allowed the Mental Health, Mental Retardation, and Substance Abuse (MH/MR/SA) Division to transfer monies from state institutions to community placements so that more people could be served in the community.

171.

The U.S. government has authorized matching federal dollars to fund 2,109 community placements through the Medicaid Waiver Program, yet the State of Georgia is using only 700 of these slots.

\* \* \*

174.

The per diem cap for community placements under the Medicaid Waiver Program for the mentally retarded is approximately \$118 to \$124 unless you request an exception.

175.

For FY '96, the per diem cost for institutional care at the Developmental Learning Center of GRH-A is \$283.

176.

For FY '95, the "adult psychiatric" per diem rate for institutional care at the Treatment Unit of GRH-A was \$219 (\$79,935 annually) and the "extended care" per diem cost was \$505 (\$184,325 annually).

\* \* \*

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF RICHARD L. ELLIOTT, M.D., PH.D.

\* \* \*

12.

E.W.'s continued hospitalization at GRH-A has and will continue to have a negative impact on her treatment and habilitation because it is likely to contribute to her depression, dependence, and lack of motivation and because what E.W. needs, more than any other single component in her treatment, is an opportunity to learn how to develop and enhance her existing abilities in a community, rather than institutional, context.

\* \* \*

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF RICHARD L. ELLIOTT, M.D., Ph.D.

Personally appeared before me, the undersigned officer authorized to administer oaths, Richard. L. Elliott, M.D., Ph.D., who, after being duly sworn, states:

1.

My name is Richard L. Elliott, and I am more than 18 years of age. I suffer from no legal disability and am competent to testify to the matters set forth herein.

2.

This affidavit is made upon my personal knowledge of the matters set forth herein and based on my professional judgment and opinion.

3.

I am currently program director and a professor in the department of psychiatry and behavioral science and the director of the center for public health advocacy at Mercer University School of Medicine, Macon, Georgia. My curriculum vitae attached to this affidavit contains accurate information regarding my educational and professional background and publications.

4.

At the request of counsel for E.W. and L.C., I have evaluated both individuals and formed certain opinions, including whether each had received minimally adequate treatment at Georgia Regional Hospital-Atlanta (GRH-A) and whether each could have been placed in a more appropriate, integrated setting instead of remaining in a psychiatric institution. My opinions on these matters were summarized in two reports dated February 26, 1996, (E.W.) and May 17, 1996 (L.C.). I have also been deposed twice by defendants' counsel and prepared an affidavit in July, 1996. The affidavit addressed the increasingly serious problems created for E.W. by her continuing institutional confinement.

5.

The opinions and conclusions expressed in those reports, depositions, and the affidavit, have not changed with the exception that my opinion regarding the adequacy of L.C.'s current placement was based on my observations and the information provided about the community-based services being provided to her in May, 1996, when I visited the residential placement ("Nyasha Hands") on Midway Road in Decatur, Ga.

6.

If L.C. is no longer residing at "Nyasha Hands," no longer attending the Community Friendship day program, and no longer involved with the same staff, I am

unable to reach any conclusions about the adequacy of her current placement.

7.

In the case of L.C., the clinical history indicates that she was placed repeatedly in psychiatric hospitals over a 14-year period, beginning when she was a young child. The records further indicate that these hospitalizations were often because her mother found L.C.'s behavior difficult to manage. L.C.'s life has thus been substantially disrupted by psychiatric hospitalizations, despite consistent indications throughout this long history that more support and structure as well as developmental and behavior management training was needed to enable L.C. to function in a community, rather than an institutional setting.

8.

Because of L.C.'s mental retardation, minimally adequate habilitation must focus on the acquisition and maintenance of life skills which will enable her to cope more effectively with her own needs and with the environment and it must focus on raising the level of her physical, mental, social, and vocational abilities. Her lengthy history in psychiatric hospitals provides clinical evidence that, in her case, this type of habilitation has not been and cannot be accomplished in this setting.

9.

Since at least 1986, professionals with a background and expertise in mental retardation have consistently



noted that L.C.'s needs as a mentally retarded adult cannot be adequately met in a psychiatric hospital, although brief periods of hospitalization may occasionally be necessary to stabilize acute psychiatric symptoms.

## 10.

In order to break her pattern of constant re-hospitalizations, L.C. must have the opportunity to learn to manage her behavior in a staffed, supportive, and structured community setting. L.C., because of her mental retardation, does not successfully transfer what is learned about managing behavior (and other social and adaptive skills) from an institution to a community setting. Also, because of her mental retardation, L.C. has probably learned maladaptive behavior as a direct result of her institutionalization in psychiatric facilities since she models the behavior which she observes.

## 11.

For L.C., habilitation in the community is needed at this point to counteract the dependency and lack of skill development resulting from years of institutionalization, much of which may have been unnecessary and inappropriate.

## 12.

For E.W., the bases for my conclusion that she requires habilitation in the community rather than in an institution are essentially the same as those upon which my conclusions regarding L.C. are based.

## 13.

In E.W.'s case, the constant, repetitive psychiatric hospitalizations provide clinical evidence that this revolving door cycle is increasingly counterproductive.

## 14.

Like L.C., it is unlikely that E.W. can learn how to maintain and enhance her capacity for independence, acquire and maintain those life skills which will enable her to cope more effectively with her needs and with her environment, and receive the kind of habilitation needed to raise the level of her physical, mental, social, and vocational abilities while in a psychiatric institution; such goals must be advanced in order to provide her with minimally adequate habilitation.

## 15.

E.W., while exhibiting signs of learned dependence on institutional routines, also suffers from frustration, depression, and hopelessness in an institutional setting.

## 16.

Like L.C., E.W.'s combination of emotional problems and mental retardation, require a supported, structured environment within which she would have the only realistic opportunity to maintain and acquire the behavioral and adaptive skills needed to live with reasonable success in the community. Based on my review of E.W.'s individual clinical history, this opportunity cannot be provided in a psychiatric institution.

17.

Under these circumstances, therefore, E.W. requires habilitation services in a community setting to provide her with the opportunity to acquire the skills she needs to live outside of an institution.

18.

In light of L.C.'s and E.W.'s particular capabilities, disabilities, and clinical histories, habilitation must be provided to them in an environment where their existing skills can be maintained and where they have an opportunity to increase their capacity to function more independently. For E.W. and L.C., this cannot be accomplished in a psychiatric institution.

Further the affiant saith not.

This 16th day of August, 1996.

/s/ Richard L. Elliott, MD PhD  
Richard L. Elliott, M.D., Ph.D.

Sworn to and subscribed  
before me this 16  
day of August, 1996.

/s/ Illegible Morris  
NOTARY PUBLIC

My Commission Expires  
Jan. 10, 2000

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Dr. Debacher's Evaluation of E.W., Undated, Fall 1995

\* \* \*

Elaine has become so worn out in this environment that she would benefit from a complete change of scene to help her climb out of her depression and take renewed interest in life. Our hospital was never intended for long-term habilitation (except DLC which serves lower functioning retardates), and our relatively spartan physical and social environment is intended to inspire patients to return quickly to life outside. It is unavoidably lacking as a long-term growth environment.

\* \* \*

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ATLANTA LEGAL AID SOCIETY, INC.  
~~DEKALB~~/GWINNETT OFFICE  
 340 WEST PONCE DE LEON AVENUE  
 DECATUR, GEORGIA 30030  
 (404) 377-0701  
 (FAX (404) 377-2349

[LETTER HEAD OMITTED IN PRINTING]

March 20, 1995

Richard Fields, M.D.  
 Superintendent  
 Georgia Regional Hospital at Atlanta  
 3073 Panthersville Road  
 Decatur, Georgia 30034

Re: ELAINE WILSON  
 formal Complaint  
 GRH-A/Protection and Advocacy Policy  
 1160

Dear Dr. Fields:

Ms. Wilson, age 43, is a patient on the Treatment Unit, who has been unable to resolve her complaint at the unit level and is at serious and immediate risk of inappropriate discharge to a homeless shelter or personal care home without adequately trained staff.

We learned of Ms. Wilson's impending discharge on Friday, March 17, 1995. Pursuant to the above policy, I contacted the consumer specialist, Ms. Sherry Olvey, but she was unable to reach the client's physician, Dr. Patel. Ms. Olvey did promise that Ms. Wilson would not be released until a meeting was scheduled with hospital staff to consider placement options. On March 20, 1995, Ms. Olvey contacted us to advise that the treatment team still

intended to discharge to a shelter but they would give Ms. Wilson's mother "a few days or a week" to locate placement. No further meetings are planned.

In light of the risk to Ms. Wilson, I do not feel I can wait before initiating this formal process, although we are always hopeful that solutions to complaints can be secured informally. Our concern is that a review of Ms. Wilson's record on March 17th clearly indicated that her treatment team intends to release her to a shelter. Her social worker, according to the record, awaits a contact from the Homeless Task Force for shelter placement.

Ms. Wilson is mentally ill, mentally retarded, and in need of appropriate, supervised, community-based mental health services and habilitation. She is incontinent of urine and feces and has behavior problems, all of which would, we believe, make shelter placement punitive, remarkably inappropriate, and absolutely doomed to failure. It strikes us as the complete opposite of what the new Mental Health Code promises Georgia's mentally disabled as well as a specific violation of her right to assistance in securing appropriate community services and programs. The record does not reflect any contact with mental retardation services, supportive living, supervised group home options, etc.

I look forward to a prompt investigation and response.

Sincerely,

Susan C. Jamieson

SCJ/b

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**IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION**

[Caption Omitted In Printing]

AFFIDAVIT OF DR. DILIPKUMAR PATEL

\* \* \*

1.

My name is Dilipkumar Patel and I am over the age of majority and have no disabilities which would render me incompetent to give this affidavit. I make this affidavit in support of Defendants' motion for summary judgment in the above referenced case, which I understand is being filed with the court. Records which are attached hereto are copies of E.W.'s medical records which are kept in the course of business at Georgia Regional Hospital at Atlanta.

2.

I am a Board Certified Psychiatrist licensed to practice in Georgia. I received my Medical Degree from Baroda, India, in 1979, after completing a year of internship. I undertook post-graduate studies for approximately a year and a half after I received my M.D., and I then immigrated to the United States in 1980. From 1980 to 1984 I worked with physicians at the Medical Center in Brooklyn, New York, and other hospitals. I completed my residency at St. Francis Hospital in Pittsburgh, Pennsylvania, from 1984 to 1988. That hospital is a psychiatric hospital and I treated patients with a broad range of problems including mental illness, mental retardation,

and substance abuse. I was then licensed to practice in Georgia, and I became board Certified in Psychiatry in 1991.

3.

I started work at Georgia Regional Hospital in 1988. In July 1994 I became the Medical Director of the Treatment Unit at Georgia Regional Hospital at Atlanta, which is a 60-bed unit for treatment of patients with acute and long term psychiatric illnesses.

4.

I treated L.C. on the Treatment Unit in July 1994. Her diagnosis was Schizophrenia, Undifferentiated Type, Chronic; and Mild Mental Retardation.

5.

During this time, and the entire time she was at GRH-A, L.C.'s treatment was provided under an individualized Treatment Plan developed by appropriate professionals who were adequately trained to assess L.C. and to recommend her treatment. The treatment which was provided to L.C. under her treatment plan was at all times appropriate for her needs. At all times that L.C. was at GRH-A, in my opinion she needed to be there for treatment.



6.

Prior to L.C.'s trial visit with her mother starting in May 1995, it was my opinion that she was not ready for discharge.

7.

In regard to E.W., her records show that she was first hospitalized at age 14 at Gracewood State School and Hospital where she was diagnosed as having mild to moderate mental retardation. She was later hospitalized at Central State Hospital with a diagnosis of schizophrenia.

8.

She was admitted to GRH-A for the first time in approximately 1974 and was frequently readmitted during the 1980's. In 1987 she was admitted to GRH-A for reportedly attacking a home provider and the provider's grandchild with a knife.

9.

Her diagnoses at various times have included Organic Personality Syndrome; Adjustment Reaction; Schizoaffective Disorder; Psychotic Disorder, Not Otherwise Specified; Borderline Personality Disorder; and Mild to Moderate Mental Retardation.

10.

E.W. was involuntarily admitted to my Unit on December 20, 1994 based in part on a Form 1013, which is an "Emergency Admission Certificate" signed by a licensed physician, psychologist or clinical social worker. The certificate stated that E.W. appeared to be mentally ill, that she had auditory and visual hallucinations, was paranoid, and was too "loose" to care for herself. (Doc. No. 9440)

11.

On admission to GRH-A, E.W. was examined by a psychiatrist who stated that she "reports visual hallucinations (demons)," and also that she "reports hearing the voice of her grandfather." He also noted that she reported feeling groggy and falling down since her medication was changed. (Doc. Nos. 8605 and 8606) His diagnostic impression was that she had a drug induced psychotic disorder, mild mental retardation by history, borderline personality disorder by history, and various physical disorder, including obesity, urinary incontinence to be studied, and a toxic reaction to Tegretol.

12.

On this admission, E.W. was 44 years old and had been admitted to this hospital more than 30 times since 1975. Her record included reports of auditory and visual hallucinations, delusions, aggressive and violent behavior, suicidal behavior, and depression. In my opinion her

diagnosis is Borderline Personality Disorder and Mild Mental Retardation.

## 13.

E.W. consented to voluntary treatment on December 30, 1995. (Doc. No. 8978) A treatment plan was developed for E.W. by the treatment team, including myself, the case manager/social worker, nurse, activity therapist, and social work supervisor. Her symptoms identified in the plan included her reaction to Tegretol, verbally abusive behavior, physical aggression, potential for noncompliance in placement, hygiene, and overflow incontinence. (Doc. Nos. 8671, 8672, 8675, 8677, 8684) Her treatment included medication, activity therapy, structure, group therapy, hygiene class, and other classes.

## 14.

On three occasions E.W. stabilized, and it was decided by myself and the treatment team that she should go on a trial visit away from the hospital in transition to discharge. In December of 1994 and in January and February of 1995, trial visits were arranged to personal care homes. However, on these occasions E.W. was returned to the hospital due to (1) her abusive verbal outbursts and apparent suicidal behavior (running into the street) (December) (Doc. No. 9441), (2) misconduct on the part of a personal care home staff and E.W.'s threat to the kill staff (January) (Doc. No. 8985), and (3) her hostile behavior and abusive verbal outbursts (February) (Doc. No. 9083).

## 15.

We continued to treat E.W. as a voluntary patient at GRH-A. However, in March, E.W. refused to cooperate with her treatment and tore up her treatment plan during a treatment team meeting. Although I can begin an involuntary commitment procedure for a voluntary patient who withdraws consent for voluntary treatment, E.W. did not meet the criteria for involuntary commitment at that time so I did not initiate the involuntary commitment procedures. Therefore, it was decided by myself and the treatment team that she should be discharged.

## 16.

E.W.'s attorney, Sue Jamieson, made a complaint at that time. As I understood her complaint, she wanted the hospital to keep E.W. until a community placement for E.W. including mental retardation services was provided, and she also believed the primary focus of her treatment should be on E.W.'s mental retardation instead of her mental illness.

## 17.

In response to Ms. Jamieson's complaint, I consulted with Dr. Gary DeBacher, Chief of the Psychology Staff, and Willie Ingram, Team Coordinator, from the Developmental Learning Center, GRH-A's Intermediate Care Facility for the Mentally Retarded (ICF/MR).



18.

Willie Ingram (M.S. Psychology), along with Priscilla Metoyer (MSW), and Denalla Ausborn (M.S. Psychology) evaluated E.W. and concluded that she was a very challenging patient. They agreed with me that the mental retardation component of her diagnosis did not appear to be the area requiring focused treatment, but rather their personality disorder. (Doc. No. 9439) Similarly, Dr. DeBacher concluded that E.W.'s behavior problems appeared mainly related to her borderline personality structure and to her depression and not to insufficient retardation services.

19.

A special staffing was held on April 19, 1995, to discuss these matters. (Doc. No. 9138) It was determined that E.W. would continue her hospitalization at GRH-A with the staff working with her on treatment goal #6, noncompliance with placement, and with additional efforts by Dr. DeBacher. (Doc. No. 9138)

20.

We continued to treat E.W. in the hospital. In addition to her mental problems, E.W. also had some serious physical problems, at times including urinary incontinence, bladder and renal problems of unknown cause, significant weight loss and dehydration through refusal to eat, balance problems, and others. These have at times required testing, treatment and close monitoring, as well as treatment at Grady Hospital. I have followed these

problems myself and consulted with other physicians and specialists as required. Testing, treatment and monitoring have all been made more difficult due to E.W.'s refusal to comply at various times.

21.

E.W. has a complicated psychopathology which makes her diagnosis difficult and controversial. For example, during this admission Dr. DeBacher evaluated her and his conclusion was different from mine. I also reviewed Dr. Elliott's evaluation, and his report included a diagnosis different from both myself and Dr. DeBacher. As stated previously in this affidavit, she also had other diagnoses at other times in the past.

22.

In my treatment of E.W. I first attempted the treatment methods described above, which are professionally acceptable and which have proved successful with other patients with similar problems. I also attempted to discharge E.W. to the community to personal care homes, where other patients with similar problems have been successful.

23.

When E.W.'s mental condition did not significantly improve and when she repeatedly was returned from placement in personal care homes, I consulted with other professionals at the hospital who suggested additional

professionally acceptable choices for treatment. Her treatment plan was adjusted at various times to try to address her problems.

24.

For example, in June 1995 an additional psychology component was added (Doc. No. 8682) and later a behavior management plan was implemented. That plan was developed by a behavior specialist who has worked with the mentally retarded population. (Doc. Nos. 8929 - 8932) E.W.'s mental condition and her behavior improved slowly and she has become more compliant with treatment. These improvements make it more likely that she would be able to be successful in the community.

25.

The treatment which has been provided at GRH-A has been adequate to ensure her safety and avoid unnecessary restraint. Since December 20, 1994, E.W. has been placed in seclusion twenty-three (23) times to protect herself and others, for aggressive and hostile behavior such as hitting, kicking, and attacking staff and throwing objects around other patients. On three (3) occasions she was also restrained for a short period of time for unsafe behavior. However, she has been secluded or restrained only to assure safety, and her treatment has been designed and provided to avoid unnecessary restraint or seclusion. (Doc. Nos. 8955-8969 & attachment A)

26.

A few months ago, I decided and the treatment team agreed that E.W. had sufficiently improved so that it would possible [sic] to discharge her to a nursing home if she continued to improve. In my opinion she would require the level of care of a nursing home due to her medical problems. The staff began looking for a nursing home which would accept her. However, in July E.W. was transferred out of my Unit due to a reorganization within the hospital and I am no longer her physician.

27.

In my opinion, E.W.'s treatment at GRH-A since I have treated her has always been appropriate to her needs. Generally, it is appropriate to treat a patient with E.W.'s level of severity of problems in a hospital such as GRH-A. Specifically, during the time that E.W. has been in the hospital while I have been treating her, it has been appropriate and professionally acceptable for her to be here and she has received adequate and appropriate treatment.

28.

By reason of my training, education and experience I am competent to make that treatment decision I made for E.W. In every decision I made regarding the treatment of E.W. I exercised my professional judgment and made professionally acceptable choices.



Further Affiant Sayeth Not.

This 21 day of August, 1996.

/s/ Dilipkumar Patel  
DILIPKUMAR PATEL

Sworn to and subscribed  
before me this 21 day  
of August, 1996.

/s/ Martha Sue Davis  
NOTARY PUBLIC

My commission expires:

Notary Public, Clayton County, Georgia  
My Commission Expires July 27, 1999

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**IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION**

[Caption Omitted In Printing]

**AFFIDAVIT OF EARNESTINE PITTMAN**

Comes now Earnestine Pittman who after being  
sworn was deposed and said:

1.

My name is Earnestine Pittman. I am over the age of majority and am suffering from no disability which would render me incompetent to give this affidavit. I make this affidavit based upon my own personal knowledge and the documents referenced herein, for use in Defendants' motion for summary judgment which I understand is being filed with the Court.

2.

I am the Director of the Fulton County Regional Board. The Regional Board is responsible for establishing policy and direction for disability services planning, delivery, and evaluation within Fulton County, O.C.G.A. § 37-2-5(a), which is E.W.'s region.

3.

Under what is commonly referred to as "House Bill 100" all funding for community mental retardation services is directed from the Division of Mental Health, Mental Retardation, and Substance Abuse in the Department of Human Resources to the regional boards.

4.

The regional boards are also authorized by the legislature to access funds which are appropriated by the legislature to the Department of Medical Assistance (DMA), for matching federal funds from Medicaid for providing community mental retardation services. These are used to create Medicaid waiver slots, meaning that the region is authorized to serve persons with mental retardation services in the community under the Medicaid waiver program.

5.

The Medicaid waiver program is a primary funding source in Fulton County for community residential services for persons with mental retardation.

6.

The Fulton County Regional Board does not currently have any uncommitted Medicaid waiver funding available and therefore cannot provide these services to E.W. under that program. The funding which was appropriated by the legislature to DMA for the Medicaid waiver program for the Board is being used to provide services for other disabled persons.

7.

The Board does not currently have sufficient annualized unallocated state funds available to provide community residential mental retardation services to E.W. The state funds which have been appropriated to the Board for community retardation services are being used to provide services for other disabled persons.

8.

The Board, through its Comprehensive Evaluation Team (CET), is responsible for recommending the consumers who may be served under the Medicaid waiver program in the county. The CET is composed of persons with special training and experience in the assessment of needs and provision of services for mentally retarded person.

9.

The CET evaluated E.W. in March of this year and recommended against moving her from Georgia Regional Hospital at Atlanta into the community. The Psychological Evaluation and Social Work Assessment making this recommendation are attached. Since, as stated above, funding is not available, the CET's recommendation did not affect whether services were provided to E.W.

#### FURTHER AFFIANT SAYETH NOT.

/s/ Earnestine Pittman  
EARNESTINE PITTMAN  
Director, Fulton County  
Regional Board

Sworn to and subscribed  
before me this 21 day  
of August, 1996.

/s/ Stephanie Mitchell  
NOTARY PUBLIC

My commission expires:

Notary Public DeKalb County, Georgia  
My Commission Expires August 18, 1998

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Progress Notes  
Patient Identification  
E.W.

Date: 5/17/96

Time: 6:15 p.m.

Disc.: SW

S/S#: 5

\* \* \*

Notes: Talked with Gloria Shepherd, Fulton Cty Regional Board, who states no placement is available at this time but she is aware of pt. need for placement and she was referring pt. to United Cerebral Pasley [sic] for placement and she will cont to work on day tx & placement.

B. Ligon

\* \* \*

Date: 6/10/96

Time: 3:15 p.m.

Disc.: SW

Re: E.W.

Notes: Social Service  
Received a call from Gloria Shepherd who stated no new news on replacement for E.W. She referred pt. to UCP for placement and agreed that she will contact them for an update then notify me.

B. Ligon

\* \* \*

Date: 7/17/96

Re: E.W.

Notes: was referred to Fulton Cty Regional Board for MR Services seeking day TX and MR placement. G. Shepherd FCRB, referred pt. to United Cerebral Palsy for placement with no progress at last contact. Attempted to reach her for an update. Unable to make connection at this time.

B. Ligon

\* \* \*

Date: 8-1-96

Time: 8:00 a.m.

Disc.: SW

Re: E.W.

Notes: Ms. Ligon reported that patient was on waiting list for a Medicaid Waiver Bed. It's unknown how long it will be to get that bed. Ms. Ligon also discussed the status of the referral for placement, at United Cerebral Palsy. She's also on waiting list there.

\* \* \*

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

Excerpt from Defendants' Response to Plaintiffs' Motion  
for Summary Judgment, R65, p. 3

\* \* \* \*

Defendants . . . agreed. . . . that Intervenor may be able to show that she is eligible for at least some of the community programs which she seeks. . . . Defendants also agree that Plaintiff L.C. is eligible for at least some of the community programs which she seeks.

\* \* \* \*

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

**AFFIDAVIT OF ALLEN FUTRAL, M.D.**

Personally appeared before me the undersigned who, after being sworn by an officer authorized to administer oaths, herein deposes and says:

1.

I, Allen Futral, M.D., am over the age of 18 and suffer from no disability which affects my ability to testify in this matter. I give this affidavit based on my personal knowledge, my review of the medical records of Elaine Wilson and my own training and experience in the field of urology.

2.

I am a medical doctor. I received my M.D. from the University of Virginia in May, 1991. I am currently a sixth year surgical resident in Urology at the Emory University School of Medicine and the Chief Resident in the Urology Service at Grady. I am supervised by Thomas Keane, M.D. I am presently assigned to the Urology Service at Grady Memorial Hospital, one of the teaching hospitals affiliated with the Emory University School of Medicine.

3.

As a resident my duties include the evaluation and treatment of patients with urological diagnoses at Grady Hospital through its affiliation with Emory University.



4.

I am the principal physician responsible for the care and treatment of Elaine Wilson at Grady Memorial Hospital. I practice under the supervision of Orlando Lopez, M.D. and Thomas Keane, M.D., who are the attending urologists for all Grady urology patients. Ms. Wilson has been having problems with proper urine flow from her bladder. On February 19, 1997, I performed a surgical procedure to permanently divert the flow of urine away from the urinary bladder and toward an external opening created on Ms. Wilson's abdomen. This surgical procedure is known as the creating of an ileo conduit. I have managed Ms. Wilson's post-operative care following surgery.

5.

In the course of my medical training and urology residency, I have performed or assisted in the performance of approximately 30 surgeries to create permanent urinary diversions, that is, ileo conduit surgeries such as the one performed for Ms. Wilson on February 19th, 1997. The purpose of such a procedure is to divert urine from the urinary bladder. Under normal circumstances, a tube, known as the ureter carries urine made in the kidney to the bladder where it is retained until the bladder is emptied during voiding. In the creation of an ileo conduit, the ureter is brought out onto the external abdomen through an opening surgically created using a piece of bowel as a conduit. This provides a permanent diversion of urine to the skin through a stoma.

6.

After surgery to create an ileo conduit, urine flows through the ureter and exits the body through the stoma. This urine is captured in a plastic bag which has an adhesive backing which sticks to the skin of the external abdomen. The bottom of the bag has an open and close valve so that urine may be emptied routinely without removing the bag from the abdomen. The bag is worn directly on the abdomen beneath clothing. Generally, the bag is emptied into the toilet and patients treat this function as if it were the same as normal voiding.

7.

Post-hospital care for an ileo conduit is relatively simple. Typically, the ileo conduit bag is changed once per week and the urine bag is emptied from the bag several times a day. The bags are disposable and not reused. Care of the stoma entails washing around the surrounding skin with soap and water and assuring that the skin is dry before a new bag is attached.

8.

In Ms. Wilson's case, the problem with urine flow from the bladder was treated by catheterization for at least twelve months until August, 1996. Catheterization is a process whereby urine is removed from the bladder several times a day by inserting a tube into the bladder through the urethra and this kind of care requires more professional attention than does management of an ileo conduit. However, catheterization is usually handled on

an outpatient basis and would not require hospitalization or institutional care.

9.

Ms. Wilson was admitted to Grady Memorial Hospital with compromised kidney functioning in August, 1996, and nephrostomy tubes were inserted as a temporary measure to improve her kidney function. These tubes removed urine from the body much the same way as the ileo conduit. The tubes, because of the risk of infection at the point of entry through the back into the body, require more care and attention than a permanent ileo conduit. Prior to Ms. Wilson's release from her current admission to Grady Hospital, the nephrostomy tubes will be removed and the areas where the tubes were inserted will begin to heal over, although they should be watched for any signs of infection until completely healed. The only medical attention involved would be to change the dressing once a day during the healing process which lasts about a week after discharge.

10.

Ms. Wilson's ileo conduit surgery was successfully completed and her post-operative course has not presented any unusual problems. Her post-operative care is anticipated to require 10-20 days of hospitalization, a period of time which would enable her to become familiar with care of the stoma and the regular emptying and replacement of the plastic urine bag.

11.

During the 9 days that I have recently observed Ms. Wilson, as her recovery progresses, she has been alert, cooperative, and cheerful.

12.

Care of the ileo conduit is routine for most patients and does not require professional medical intervention. Typically, patients learn how to empty and replace the bags themselves. Most patients perform their own care of the stoma. Persons with no medical training can easily be taught how to clean the stoma, apply the bag, and empty the urine from the bag. Patients with limited mental abilities can be taught to perform self-care. In light of Ms. Wilson's mental retardation, this intervention was chosen so that management of the urinary diversion would be as simple as possible. The literature and my experience would support this as the best approach to maximize Ms. Wilson's independence and to minimize long-term complications.

13.

In Ms. Wilson's case, I would recommend that she have supervision in caring for the stoma and changing the bag until she is fully capable and comfortable with the process. This supervision and assistance does not have to be provided by nursing personnel. Based on my contact with Ms. Wilson, there is no indication that she is unable to learn how to self-manage her ileo conduit care.



One of the goals of the surgery was to assist Ms. Wilson in maximizing her ability to engage in a more normal life.

14.

Although Ms. Wilson will require outpatient medical monitoring of her ileo conduit and renal condition and attention to her anemia after she is discharged from Grady, the degree of care would not require nursing home or other institutional care. It is the experience of most patients that an ileo conduit does not significantly interfere with their ability to lead a normal life.

15.

There are no plans for further surgical treatments for Ms. Wilson at Grady Hospital. All her urological needs could be met in a community setting. Any necessary monitoring of her condition could be done in a community setting. From a urological standpoint, it is my opinion that she can readily be treated in a community setting and I would not hesitate to release her to such a placement if one were available.

Further affiant sayeth not.

/s/ Allen Futral, M.D.  
ALLEN FUTRAL, M.D.

Sworn to and subscribed  
before me this 27th  
day of Feb., 1997.

Notary Public, DeKalb County, Georgia  
My Commission Expires June 11, 1999

/s/ Albert R. Spearman  
NOTARY PUBLIC

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

**AFFIDAVIT OF DIANE COBB**

Comes now before me the undersigned, who, being duly sworn, deposes and says:

1.

I, Diane Cobb, am over the age of 18 and competent to make the statements. Each is based on my personal knowledge and observations of Elaine Wilson and her circumstances, my clinical training and experience, particularly in the areas of mental health and mental retardation, and my experience as a provider of community residential services to mentally disabled adults.

2.

I am a registered nurse, licensed to practice in Georgia since 1973. I received my nursing degree from Manhattan College, New York City, New York, in 1972 and have been a practicing nurse for 24 years. My nursing career has been principally in the area of mental retardation, providing a combination of nursing and habilitation services to persons with mental retardation.

3.

Currently, and for the past 2 years, I have been a provider of community-based residential programs for mentally disabled adults, including a "personal support"

program for a mentally retarded adult through the Mental Retardation Waiver Program, a program designed to provide services in the community to persons who would otherwise be institutionalized or at risk of institutionalization. In addition to the provision of community services as a private provider, I am also a consultant with the DeKalb County Community Service Board (CSB), a public provider of mental health and mental retardation services. In this capacity, I train CSB staff, provide nursing services to clients, and follow-up care for physicians. I have also provided training to other home providers as an independent consultant.

4.

Prior to my current activities, I worked extensively with the developmentally disabled, mentally retarded, and physically handicapped as a nurse for 18 years, including seven and one-half years at the Stillwater Health Center, an institution for persons with mental retardation in Dayton, Ohio, 4 years at a similar institution in Willowbrook, New York, and 5 years at the Developmental Learning Center, a residential institution for the mentally retarded adults at Georgia Regional Hospital at Atlanta (GRH-A). During the period that I worked at the Developmental Learning Center, from 1985 to 1989, I was involved in the development of numerous transitional plans for persons who moved from the institution to the community as the result of a lawsuit.



5.

Typically, the habilitation plans for people moving out of institutions into the community address three areas: training/habilitation, behavioral problems, and medical problems.

6.

In my experience with the habilitation of mentally retarded and mentally ill adults in community settings, medical problems and needs are approached the same way such problems and needs would be addressed for anyone with a similar problem, that is with appropriate medical oversight on an outpatient basis, including home health services, if necessary. If a medical emergency arises, appropriate emergency medical services are utilized.

7.

Persons with mental retardation have a variety of medical needs requiring daily monitoring, such as feeding tubes, catheters, colostomies, dialysis, high blood pressure and other conditions that affect the general population. All of these conditions can be successfully managed in a community residential program.

8.

In many instances, it is easier to provide medical services to a person who is resistant or who has limited understanding in a community rather than an institutional setting because it is a calmer environment, there is

more individualized attention, and much greater flexibility for staff, who are experienced in working with the mentally retarded, to find successful ways to encourage and support the individual. For example, if a person is uncooperative with treatment or in a negative mood, it is easier in a home-like community residential setting to simply wait for an opportunity at another time.

9.

I am acquainted with Elaine Wilson. When I was a nurse at GRH-A, I had occasion to work on all the units and Ms. Wilson was frequently admitted during those years in the late 1980s. More recently, I visited her at GRH-A on October 19, 1996, when she was on the "East" unit. On that occasion, I spoke to her for about an hour, spoke informally to staff on the unit, and reviewed her record, including admission notes and progress notes before and after she was hospitalized at Grady Memorial Hospital in August, 1996. I was focusing particularly at that time on any medical problems to determine whether they could be met in a community setting.

10.

On the day that I met with Ms. Wilson, she had bilateral nephrostomy tubes. The tubes were filtering properly, there was no sign of infection, and she was in no immediate distress or pain. It was my understanding at that time that she anticipated surgery to replace the tubes with a permanent ileo conduit. I did not see any great difficulty in meeting Ms. Wilson's medical needs in a home or community setting through the medicaid waiver

personal support program, enlisting the assistance of home health aids.

## 11.

Ms. Wilson, in my view, would greatly benefit from habilitation activities designed to develop and regain her abilities to function independently. These activities would include cooking, shopping, home maintenance, public transportation, socialization skills, and many other activities related to the normal activities of life in a community setting.

## 12.

In my view, Ms. Wilson's behavior problems are likely to decrease significantly or disappear in a structured community residential program because they seem to be directly related to her need for individualized attention and productive activity. In my experience, persons with mental retardation and mental illness, especially if they have been frequently institutionalized, often have long-standing behavior problems which can be more effectively addressed in the community where the individual can form a consistent relationship with one or two trained staff in a supportive environment.

## 13.

Since my visit with and assessment of Ms. Wilson in October, 1996, I have been advised that she had ileo conduit surgery. I am familiar with the care of a person with an ileo conduit, that is, the routine emptying of the

bag on a daily basis and the regular replacement of the bag which is usually done once a week. This is routine care that many people handle without assistance and Ms. Wilson may, in time, learn to self-manage her care. Care of an ileo conduit does not require placement in a hospital, nursing home, or other institutional setting.

## 14.

I am willing and able to serve Ms. Wilson in the community in a personal support and habilitation program with 24-hour supervision, including whatever nursing care is required. I am aware that Ms. Wilson must be routinely monitored for signs of renal failure, anemia, and high blood pressure and that her personal support team would need to be trained to identify these signs.

## 15.

As is the case with all mentally disabled persons served in residential community programs, including my programs, Ms. Wilson will need a comprehensive individualized service plan which would cover her habilitation and medical needs and how these needs would be met through a variety of day training, outpatient, emergency, case management, and crisis intervention services.

## 16.

It is my opinion that Ms. Wilson is not a particularly challenging person to serve in a community setting with



adequately trained staff, structured activities, and sufficient opportunities for her to enhance and increase her independent living skills.

Further affiant sayeth not.

/s/ Diane Cobb  
DIANE COBB

Sworn to and subscribed  
before me this 25  
day of Feb., 1997.

Notary Public, DeKalb County, Georgia  
My Commission Expires June 11, 1999

/s/ Albert R. Spearman  
NOTARY PUBLIC

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THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF CARL E. ROLAND, JR.

\* \* \*

1.

I, CARL E. ROLAND, JR., am over 18 years old and base these statements on my personal knowledge of the matters discussed in this affidavit.

2.

I serve as the Director of the Division of Mental Health, Mental Retardation, and Substance Abuse of the Department of Human Resources for the State of Georgia. As such, I administer and supervise the State programs for mental health, mental retardation, and substance abuse, and I direct, supervise, and coordinate the State's provision of facility-based services for Georgia residents with the conditions of mental illness, mental retardation, or substance abuse, or with combinations of these conditions. The Division and the Director's position are established and governed by statute, e.g., O.C.G.A. § 37-1-20.

3.

The defendants currently have no funds with which to implement the Court's order for adding a community placement for E.W. To secure these funds, they will have no recourse but to terminate or reduce State services to one or more other persons already being served, or to

delay services to other facility-based persons. My understanding from professional staff is that E.W. is receiving at least minimally adequate care in her present placement for her current requirements.

## 4.

More specifically, funds for E.W.'s community placement would have to come from the Fulton County Regional Board, in accordance with O.C.G.A. §§ 37-2-5.1(c), 37-2-5.2(a)(2). The director of that Board, Earnestine Pittman, has already stated in an affidavit that the Board (1) "does not currently have any uncommitted Medicaid waiver funding available" and (2) "does not currently have sufficient annualized unallocated state funds available to provide community residential mental retardation services to E.W." In addition, the Fulton Regional Board, as does each of the other eighteen Boards, has begun to maintain an extensive waiting list of individuals who are seeking but are not receiving facility-based or community-based services.

## 5.

There are no other funds currently available. First, the remainder of the current appropriation received by the Division from the General Assembly has been allocated to the other Regional Boards to fund the operation of their programs, as authorized by O.C.G.A. § 37-1-20(b)(8). Second, the "discretionary fund" of \$300,000 mentioned several times by the plaintiffs in their documents in this case was intended for providing emergency placements, and it was completely expended long

ago. Third, the Department of Medical Assistance for the State of Georgia has required that all new "Medicaid waiver" funds be used to provide community placements for residents in ICF/MR State facilities such as Brook Run, whose closing was directed by the General Assembly in the Session that just ended. This position is stated in the letter of Marjorie P. Smith, Commissioner, to Gail W. Reed (Jan. 16, 1997), in Ex. 11 of "Plaintiffs' Response to Defendants' Supplemental Brief in Support of Defendants' Motion for Summary Judgment and in Opposition to Plaintiffs' Motion for Summary Judgment" (served Mar. 3, 1997).

## 6.

Finally, although the Division is authorized to move funds between facility-based programs and community-based programs, such a transfer must be accomplished in compliance with the provisions of the Appropriations Act and other applicable laws, according to O.C.G.A. § 37-2-5.1(c)(3). The Division is charged by law (e.g., O.C.G.A. § 37-1-20) with establishing and maintaining both community placements and institutional placements. It cannot comply with its duty to provide adequate facility programs if it moves any more of its facility funds to community programs.

## 7.

The only way in which E.W.'s community placement can be funded at this time is by terminating or reducing State services for a person or persons now receiving them. As an administrator and as a human being, I do not



find this to be a satisfactory alternative, particularly when it is used on an interim basis pending appeal.

8.

I have read the Court's opinion, and I interpret it to mean that since E.W. can be treated in the community, she *must* be treated there. Many administrators and professionals in this field, including myself, believe that virtually anyone *can* be treated in the community, given unlimited funds, personnel, and other support. This does not mean, though, that persons can *not* be treated in a facility, or that they do not need facility-based care, or that it is always better to treat them in the community. The State has legitimate interests in maintaining facility-based programs as part of its spectrum of care.

9.

I think that many persons currently receiving care in our facilities will believe, just as E.W. believes, that they can be treated in the community. I predict that many of their representatives will seek community placements for them by filing lawsuits against the State like this one, if the decision in this case is not stayed. Based on our experience with other litigation, I know that a large number of lawsuits will drain substantial amounts of time, energy, and money from the Division and will significantly impede its work in providing care.

10.

Placing just E.W. herself in the community now, if this decision is not stayed, would entail substantial expense. The projected annualized cost of L.C.'s community placement was \$88,455, and E.W. has substantially greater needs than L.C.

11.

Requiring immediate placement of E.W. in the community, if the Court's decision is not stayed, would deprive the Division and the Regional Boards of their lawful authority to exercise their professional expertise and discretion in making treatment decisions. The Division and the Regional Boards are required to make very difficult decisions in distributing the appropriated funds to achieve maximum benefit and balance the needs of many eligible recipients of public services.

12.

Despite the plaintiffs' allegations to the contrary, the Division has used its discretion to downsize facility programs and expand community services. The Division planned and implemented the closing of Rivers Crossing, an Athens, Georgia, unit of Brook Run, in 1996. In this process, all beds at the facility were closed, and 36 children and young adults were moved to well planned and funded community placements.

The Division, in cooperation with some of its Regional Boards, closed two mental retardation units at Bainbridge State Hospital, Bainbridge, Georgia, which

permitted 27 individuals to live in the community. In addition, the number of persons added in home and community based Medicaid waiver slots from the fiscal year 1991 to the present has increased by 1,919 persons. This includes a number of consumers who have never received services, as well as providing a more comprehensive set of services to better meet the needs of existing consumers. The waiver has allowed the State to make more efficient use of limited state funds by matching them with federal dollars.

The Division also committed to closing Brook Run itself, and the General Assembly has now directed that closure to be accomplished by December 31 of this year. As a consequence, 326 persons will be moved from facility settings to community placements by that date.

13.

The granting of a stay of the Court's decision pending appeal will permit the Division and the Regional Boards to avoid disruptions to other persons' services during the appeal, and it will allow planning and implementation of large-scale changes in the delivery of services, if necessary, based upon a final appellate decision.

Further affiant sayeth not.

/s/ Carl E. Roland, Jr.  
CARL E. ROLAND, JR.

Sworn to and subscribed  
before me this 17 day  
of April, 1997.

/s/ Rosemary Murphy  
NOTARY PUBLIC

Notary Public, Fulton County, Georgia  
My Commission Expires Oct. 18, 1997

[SEAL]

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF PHILLIP A. HORTON, M.D.

\* \* \*

1.

I, PHILLIP A. HORTON, M.D., am over 18 years old and base these statements on my personal clinical evaluation of E.W., my review of pertinent portions of her medical chart, and my discussions with her current caregivers.

2.

I am licensed to practice medicine and surgery in the state of Georgia. I received my medical degree from the Medical College of Georgia in 1986. Subsequently I completed two residency programs at Medical College: the first, in internal medicine, from 1986 to 1989, and the second, in psychiatry, from 1989 to 1992. I am Board-certified in both of these specialties.

3.

Since 1992, I have served as psychiatrist and internist on a geriatric unit at Georgia Regional Hospital/Augusta, and then as Clinical Director at Georgia Regional Hospital/Savannah. Both of these State hospitals are primarily mental health facilities. I also served concurrently as

Assistant Clinical Professor in Psychiatry at Medical College from 1992 to 1995 current (P.H.) I have given continuing medical education presentations on "Medical Diseases that Present with Psychiatric Manifestations" and on "Use of Psychotropics with Consumers Dually Diagnosed MI/MR."

4.

I have served as Clinical Director at Gracewood State School and Hospital since May 1, 1996; that is my current position. Gracewood is a State facility for persons with mental retardation. The clients there range from those with mild retardation and no physical limitations to those profoundly retarded and requiring skilled medical care. Additionally, I currently serve as a captain in the Medical Corps, United States Army Reserve. In that part-time position I practice internal medicine exclusively.

5.

I consulted on E.W.'s case on April 1, 1997, and I completed my consultation report that same day. Attached to this affidavit and incorporated in it is a true and correct copy of that report. In the remainder of this affidavit, I will highlight the significant findings in my report.

6.

I saw E.W. at her current placement on the second floor of the Medical Surgical Hospital at Central State Hospital in Milledgeville. That floor operates as a nursing

facility within the Hospital. E.W. is a renal patient, and she is a person with mild to moderate mental retardation.

7.

E.W. has fairly serious problems related to her renal status. One of her current medical diagnoses is azotemia, which is the presence of urea or other nitrogenous bodies in the blood. Her most recent lab work shows, for example, a BUN (blood urea nitrogen) reading four times the normal amount, and a creatine reading three times normal. For this reason I have concluded in the Discussion part of my report that E.W. "requires intense medical monitoring of her current renal functioning, including: daily fluid Input and Output on all shifts, daily protein intake, daily weights, caloric counts, periodic electrolyte and renal monitoring." Her renal status, along with her continuing to heal after her recent surgery, is the reason that she is "too weak for most independent activities of daily living and therefore requires assistance (bathing, walking, toileting, eating, etc.)," as I noted in the report.

8.

Another serious problem is that E.W. is colonized with Vancomycin Resistant Enterococcus. That organism is bacteria of the human intestine for which there is no known antibiotic. To be "colonized" means that she is carrying it as a resident. It can spread to others, particularly others who are debilitated. Managing its effects requires, as I note in my report, "scrupulous sanitary

conditions," and "[i]t is unlikely this could be done anywhere other than a hospital or nursing home." This problem may well be exacerbated, as I noted, by the fact that "[d]espite an ileal conduit, the client continues to have urinary incontinence, wetting her undergarments. . . ."

9.

For the present, E.W. requires continued care in a nursing facility. I am unable to state at this time, to a reasonable medical certainty, how long she will need to remain there. She will continue to be treated and monitored for improvement.

Further affiant sayeth not.

/s/ Phillip A. Horton, M.D.  
PHILLIP A. HORTON, M.D.

Notary Public, Richmond County, Georgia  
My Commission Expires, Aug. 19, 2000

/s/ Ann W. Copiland  
NOTARY PUBLIC

Sworn and subscribed before me  
this 8th day of April, 1997.

---



## CENTRAL STATE HOSPITAL

## CONSULTATION SHEET

QUEST - PARTS I, II AND III MUST BE COMPLETED BY  
REQUESTING PHYSICIAN

/s/ Dr. Gill FROM: /s/ GL Echols Md

DATE OF REQUEST: 3/10/97

## REASON FOR REQUEST &amp; PROVISIONAL DIAGNOSIS:

*Follow up consultation to render current opinion of psychiatric  
& M.R. status with most likely diagnosis (-es). Please see  
attached info.*

*Thanks, GLE*

## RECEIVING FOLLOWING DRUGS:

- |                     |                  |
|---------------------|------------------|
| 1. <u>Depakote</u>  | 2. <u>Zoloft</u> |
| 3. <u>Risperdal</u> | 4. _____         |
| 5. <u>Klonopin</u>  | 6. _____         |

## PSYCHIATRIC SUMMARY:

DEBTOR'S SIGNATURE PLACE OF CONSULTATION

☐ BEDSIDE

☐ EMERGENCY

☐ ON CALL

☐ ROUTINE

NATURE AND TITLE

E.W.

/s/ L Gill MD 618

3/11/97

March 11, 1997 CONSULTATION REPORT E.W.

The patient was interviewed in her room and her chart was reviewed. Her psychiatric assessment is as follows:

1. Is she currently mentally ill, that is, having a disorder of thought or mood which significantly impairs judgement, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life?

This patient appears to be in remission of what appears to be a chronic schizophrenic illness, paranoid type. She currently has no significant symptoms or any delusional thinking and is under fair remission with the antipsychotic Risperdal. She has good reality testing and appears to be able to cope with the ordinary demands of life.

2. Does she represent a substantial risk of imminent harm to herself or others?

This patient does not appear to pose a significant or substantial risk to herself or others. She has no such ideations and has made no such gestures.

3. Is this facility a least restrictive treatment setting that is available?

This patient could possibly be managed in a less restrictive setting with the appropriate medical and psychiatric follow up.

## VOLUNTARY INPATIENT CARE:

- A. Does patient presently meet each of the standards established for such care, that is, does she show evidence of mental illness and is she suitable for treatment? The patient has occasional auditory hallucinations and appears to be in remission of most of her psychiatric symptoms at this time. She, however,

needs continuing psychiatric treatment to avoid relapse of her psychiatric illness and therefore meets the criteria for continuing treatment.

- B. Is patient competent to seek voluntary admission to a facility? The patient is competent to seek voluntary admission.
- C. If she is competent, is she requesting voluntary admission? She has not made that request at this time.
- D. Does E.W. meet each of the standards for involuntary outpatient treatment, that is, is she mentally ill? No.
- E. Based on a treatment history or current mental status will she require outpatient treatment in order to avoid predictably and eminently becoming an inpatient? Yes.
- F. Because of her current mental status, mental history or nature of her mental illness, is she unable voluntarily to seek or comply with outpatient treatment? No. I feel that she can voluntarily comply with outpatient treatment.
- G. Is she in need of involuntary treatment? No, not at this time.
- H. Is outpatient treatment the least restrictive treatment setting available to E.W. within the limits of State funds, specifically appropriated therefore? Yes.
- I. Does E.W. meet each of the standards for voluntary outpatient treatment, that is, does she show signs of mental illness? Yes.
- J. Is she suitable for treatment? Yes.
- K. Is she now clinically competent to seek community mental health services voluntarily? Yes.

- L. If she is competent, is she requesting voluntary use of community mental health services? Yes.

#### DIAGNOSIS:

- Axis I: Schizophrenia, chronic, paranoid type (in remission).
- Axis II: Borderline intellectual functioning, rule out personality disorder, not otherwise specified.
- Axis III: Chronic renal failure with ileal diversion of urinary tract.
- Axis IV: Moderate.

\* \* \*

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

AFFIDAVIT OF RICHARD ACKERMAN, M.D.

1.

My name is Richard J. Ackerman, M.D. I am an adult and competent to attest to the statements in this affidavit. I am a board-certified physician and geriatrician who teaches full time in the medical school at Mercer University. I am experienced in and familiar with the capabilities of community services and nursing homes.

2.

At the request of Susan C. Jamieson, staff attorney at the Atlanta Legal Aid Society, I reviewed the medical records and certain other documents, including the April 1, 1997, evaluation of Dr. Horton, regarding E.W. covering the period from March 3, 1997, through April 16, 1997, in order to address two of E.W.'s medical problems: (1) vancomycin - resistant enterococcal colonization of the stool (VRE) and (2) a sacral pressure sore. I was asked to assess, based on the medical records provided by Ms. Jamieson, whether E.W., because of either the VRE or the sacral pressure sore, required hospital or nursing home placement. I prepared a two page report, dated April 30, 1997.

3.

Attached to this April 30, 1997, report is an accurate copy of my Curriculum Vitae.

4.

The conclusion that I reached is that neither VRE nor the sacral pressure sore would provide an obstacle to community-based care for this individual. To the contrary, I believe that hospitalization or nursing home placement could even worsen her condition.

5.

VRE is an organism that is common in hospitals and E.W. probably acquired it during one of her many hospitalizations. Its presence is currently of only incidental significance and good handwashing is all that is required. Pressure sores are the result of immobility. In E.W.'s case, I consider the most important cause of her skin breakdown to be excessive sedation. E.W.'s medical records indicate that the Central State neurologist shares my view that she was over-sedated in his consult on March 22, 1997.

6.

I specifically disagree with Dr. Horton's conclusion that E.W. requires "a closely medically supervised setting such as a hospital or nursing home." On the contrary, despite her medical and psychiatric disabilities, E.W. would be well served by outpatient community medical care.

7.

I have set forth the bases for my conclusions in greater detail in my April 30, 1997, report, attached to this affidavit.

/s/ Richard J. Ackerman  
RICHARD J. ACKERMAN

[SEAL]

/s/ Peggy W. Taylor

Sworn to and subscribed  
before me this 1st day  
of May, 1997.

MY COMMISSION EXPIRES APRIL 18, 2000

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

SECOND AFFIDAVIT OF EARNESTINE PITTMAN

\* \* \*

1.

My name is Earnestine Pittman. I am the same Earnestine Pittman who signed an affidavit in this case on August 21, 1996. I am over the age of majority and am suffering from no disability which would render me incompetent to give this affidavit. I make this affidavit based upon my own personal knowledge and the documents referenced herein, for use by the Defendants.

2.

I continue to serve as the Director of the Fulton County Regional Board, as I did when I signed the previous affidavit. The Regional Board is responsible for establishing policy and direction for disability services planning, delivery, and evaluation within Fulton County, O.C.G.A. § 37-2-5(a), which is E.W.'s region.

3.

I have reviewed my previous affidavit. The funding situation described there has changed to some extent, so that the Board may be able to access public funding that was unavailable to E.W. at the time of that affidavit.



4.

E.W.'s psychiatric and physical condition has also changed to some extent since then, according to reports. for that reason, the Board is initiating a re-evaluation of E.W. at this time.

5.

If E.W. is found to satisfy standards for community placement under Georgia law, public funding will be pursued and she will be considered for such placement in the same manner as other persons similarly situated are considered.

6.

As a result of this re-evaluation, E.W. may thus obtain a publicly funded community placement on the basis of Georgia law, the normal workings of the public health system founded on that law, and the normal operation of the Regional Board.

/s/ Earnestine Pittman  
EARNESTINE PITTMAN

Sworn to and subscribed  
before me this 19th day  
of May, 1997.

/s/ Illegible  
NOTARY PUBLIC

My commission expires:

Notary Public, Fulton County, Georgia  
My Commission Expires October 7, 2000

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

SECOND AFFIDAVIT OF PHILIP A. HORTON, M.D.

\* \* \*

2.

On May 12, 1997, I again visited Central State Hospital in Milledgeville, Georgia, to assess the patient E.W. Attached to this affidavit is my report on that assessment. I based the statements in the report on my personal clinical evaluation of E.W., my review of pertinent portions of the medical chart, and my discussion with her current caregivers.

3.

As a summary of this report, it is fair to say that E.W. has shown clear improvement since my report of April 1, 1997, which was attached to my affidavit of April 7, 1997. Her present condition does not completely preclude her being placed in a community residential placement, as her condition did on April 1. The nature, timing, and funding of such a placement, if it can be devised, are matters best left to a team of health care professionals and administrators assigned to that task. They can formulate a very specific service plan and pursue funding for it.

## 4.

The critical importance of having a team of health care professionals and administrators continue to make careful decisions for E.W. is underscored by the growing controversy in the public health community about the relative costs and benefits of the "deinstitutionalization" movement that has taken place over the past three decades. I attach two articles illustrating more recent thought on this subject. The first, "Comparative Mortality of People with Mental Retardation in Institutions and the Community," finds that for persons with mental retardation who were studied for the article, the "[r]isk-adjusted odds on mortality were estimated to be 72% higher in the community than in institutions." In the second article, "Medical Disorders of Adults with Mental Retardation: A Population Study," the authors studied a group of adults with mental retardation and found that "[c]ompared to the local population, the study group had significantly increased cardiovascular risk factors, rate of medical consultation, rate of hospitalization, and mortality." Both of these articles appeared in the *American Journal on Mental Retardation*, a refereed journal that is a standard source and a reliable authority in this field. Both have generated controversy, but certainly both raise issues requiring careful consideration by health care professionals and administrators.

Further affiant sayeth not.

/s/ Philip A. Horton, M.D.  
PHILIP A. HORTON, M.D.

(SEAL)

/s/ B.A. Stafford

NOTARY PUBLIC Comm. Expires 11-11-00

Sworn and subscribed before me

this 19th day of May, 1997.

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In the United States Court of Appeals  
for the Eleventh Circuit

**DRAFT**

Preliminary Plan

Not approved or Funded

**PROJECTED SERVICE COST****Medicaid Waiver**

|                                  |                    |
|----------------------------------|--------------------|
| Personal Support                 | \$43,165.00        |
| Service Coordination             | \$17,010.00        |
| Day Habilitation<br>(Six months) | \$ 3,700.00        |
| Medicaid Option                  | \$ 0.00            |
| <b>Total</b>                     | <b>\$63,875.00</b> |

Source: Region 5

**Psychiatric Consultation**

|                               |         |
|-------------------------------|---------|
| Local Mental<br>Health Center | \$ 0.00 |
|-------------------------------|---------|

**Community Program**

|               |                    |
|---------------|--------------------|
| Day Treatment | \$ 7,200.00        |
| Social Club   | \$ 2,160.00        |
| <b>Total</b>  | <b>\$ 9,360.00</b> |

|                                  |                    |
|----------------------------------|--------------------|
| <b><u>State Match to DMA</u></b> | <b>\$19,365.00</b> |
|----------------------------------|--------------------|

|              |                    |
|--------------|--------------------|
| <b>Total</b> | <b>\$92,600.00</b> |
|--------------|--------------------|

\* These figures will need to be adjusted based on E.W.'s actual needs post discharge. Additionally, this does not constitute a guarantee that there will not be unforeseen cost barriers.

IN THE UNITED STATES COURT OF APPEALS  
FOR THE ELEVENTH CIRCUIT

CASE NO. 97-8538

L.C. and E.W., each by JONATHAN ZIMRING,  
as guardian ad litem and next friend,  
Plaintiff and Intervenor-Appellees,

v.

TOMMY OLMSTEAD, Commissioner of the  
Department of Human Resources;  
RICHARD FIELDS, Superintendent of  
Georgia Regional Hospital/Atlanta  
and EARNESTINE PITTMAN,  
Executive Director of the  
Fulton County Regional Board,  
all in their official capacities,  
Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES  
DISTRICT COURT FOR THE NORTHERN DISTRICT  
OF GEORGIA  
CASE NO. 1:95-CV-1210-MHS

\* \* \*

Excerpt from Petition for Rehearing and Suggestion of  
Rehearing En Banc, p. 14:

\* \* \* \*

. . . . the "additional expenditures necessary to treat L.C.  
and E.W." in the community are, by definition, not unrea-  
sonable, nor could they "fundamentally alter" the ser-  
vices provided by the State.

\* \* \* \*

\* \* \*

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

L.C. and E.W. by JONATHAN ZIMRING  
as guardian ad litem and next friend,

Plaintiff,

CIVIL ACTION

v.

FILE NO. 1:95-CV-1210

TOMMY OLMSTEAD, Director of  
the Department of Human  
Resources; RICHARD FIELDS,  
Superintendent of Georgia  
Regional Hospital at Atlanta;  
and EARNESTINE PITTMAN,  
Executive Director of the  
Fulton County Regional Board,  
all in their official capacities,

Defendants.

AFFIDAVIT OF DIANE COBB

STATE OF GEORGIA

COUNTY OF FULTON

Personally appeared the undersigned, who after  
being duly sworn by an officer authorized to administer  
oaths, deposes and says:

1. I am the operator of the Nyasha Hands (Loving  
Hands) group home at 3442 Midway Road, Decatur, Ga.  
The Nyasha Hands program provides 24-hour supervi-  
sion and support by trained staff to persons with mental  
retardation. Staff assist our 3 residents with independent  
living skills, behavior management, and leisure activities  
in a 4-bedroom home in a Decatur neighborhood.

2. L.C. and E.W. have both resided at Nyasha  
Hands. L.C. arrived in February 1996 and E.W. in July  
1997. L.C. still resides there.

3. E.W. moved on September 2, 1998, after 14  
months with us, to a more independent supervised apart-  
ment setting.

4. In my view, based on more than 20 years experi-  
ence with the habilitation of persons with mental retarda-  
tion, both L.C. and E.W. are doing well and progressing  
steadily in a community setting, although they each have  
challenging needs.

5. In this affidavit, I will set out what information is  
available to me about the cost of L.C. and E.W.'s care in  
the community during the time that each resided at  
Nyasha Hands.

6. With regard to L.C., the cost of the personal care  
and staff support provided through the Nyasha Hands  
24-hour staff was not reimbursed at all during the first 7  
months after her discharge from Brook Run into our care.  
This would be approximately the period from February,  
1996 through August, 1996.

7. In September, 1996, Nyasha Hands began receiv-  
ing \$118.26 per day to cover the cost of the 24-hour  
personal care and staff support provided to L.C.

8. In addition to the per diem payment for personal  
support, an additional amount is available on weekdays  
for day habilitation services and is paid directly to the  
day habilitation provider. On information and belief, this  
amount is \$70.00.



9. L.C. pays for her own room and board through her Social Security disability and Supplemental Security Income disability benefits, less a \$60.00 personal needs allowance. This amounts to a monthly payment of \$424.00 to Nyasha Hands.

10. L.C. also has a case manager through the "Access" program of the Fulton County Community Service Board, a mental health service. The case manager maintains regular contact with L.C. and has certain responsibilities managing L.C.'s community-based program. I am not aware of the dollar value of this service.

11. It is my understanding that the \$118.00 per diem and the day habilitation expenses are covered by the Mental Retardation Waiver Program and that the funds for these services are distributed through the Fulton County Regional Board. I believe that other expenses, such as regular medical care, mental health care, and case management services are covered through other sources, such as the "regular" Medicaid program operated through the Department of Medical Assistance.

12. Based on my own informal calculations, the annual cost to the State of L.C.'s community-based mental retardation services would be the state "match" for L.C.'s mental retardation waiver "slot" or approximately \$18,500.00.

13. With regard to E.W., upon her placement at Nyasha Hands in July, 1997, we received \$118.26 per diem to cover the cost of the 24-hour personal care and staff support provided to E.W.

14. In addition to the per diem payment, a certain amount has been available to cover the cost of E.W.'s day habilitation program at Health Care Foundations. I believe this amount is \$70.00 per day and that it is paid directly to the day habilitation service provider.

15. E.W. pays for her own room and board through her Supplemental Security Income disability benefits, less a \$60.00 personal needs allowance. This amounts to a monthly payment of \$424.00 to Nyasha Hands.

16. E.W. also has a "service coordinator" through the United Cerebral Palsy Organization. The cost of the coordinator is covered under the Mental Retardation Waiver. The cost of this service is \$140.00 per month.

17. It is my understanding that the \$118.26 per diem, the day habilitation expenses, and "service coordination" are covered by the Mental Retardation Waiver Program and that the funds for these services are distributed through the Fulton County Regional Board. I believe that other expenses, such as regular medical care and mental health care are covered through other sources, such as the "regular" Medicaid program operated through the Department of Medical Assistance.

18. It is my understanding that the annual cost to the State of E.W.'s community-based mental retardation services would be the state "match" (approximately one-third of the total) for L.C.'s Medicaid mental retardation waiver "slot". This is one-third of the per diem (\$118.26 for 365 days), the day habilitation (\$70.00 for 240 days) and the service coordination (\$140.00 for 12 months).

19. According to my calculations, the cost to the State in matching funds for E.W.'s Medicaid waver [sic] slot, based on the calculations in the above paragraph is approximately \$20,548.00 per year.

/s/ Diane Cobb  
DIANE COBB

Sworn to and subscribed

before me this Sept.

day of 30th, 1998.

Notary Public, DeKalb County, Georgia  
My Commission Expires November 17, 2000

/s/ Betty Jo Illegible  
NOTARY PUBLIC

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# EVALUATION OF BROOK RUN A STATE MENTAL RETARDATION INSTITUTION

A Report Prepared by a Special Task Force  
Appointed by the Privatization Commission

November 1996

\* \* \*

## GEORGIA BACKGROUND

In 1988, a study was conducted by O'Neal and Associates, Ltd. of the feasibility of closing the Georgia Retardation Center (later renamed Brook Run). The recommendation of the study was to close the facility and place the residents of the facility in community programs. The study was endorsed by the Board of the Department of Human Resources but the Plan was later withdrawn from consideration due to a number of concerns about the planning process and political opposition.

Also, in 1988 with the first submission to the Department of Medical Assistance of the HOME AND COMMUNITY BASED SERVICES WAIVER FOR MENTAL RETARDATION, Georgia began a strategy for reconfiguring the State's publicly funded services and supports for people with mental retardation. Broadly, these strategies called for reducing the role that institutional services played in meeting the needs of such individuals while concurrently expanding the scope and availability of community residential/support services. An obligation to reduce institutional beds by 1,000 by 1997 was established in the 1992 RENEWAL OF THE HOME AND COMMUNITY BASED SERVICES WAIVER FOR MENTAL RETARDATION. As of September 1996, only 147 of the



proposed 1000 bed reduction has been realized. The limited success has been due primarily to not having identified a concentrated closure of a large enough number of institutional beds needed to generate the necessary savings. The only exception was the closure of the Rivers Crossing mental retardation facility in Athens in State Fiscal year 1996 which allowed the closure of 37 beds and concurrent placement of 37 consumers in the community.

In 1992, five hundred twenty-three (523) individuals currently residing in state mental retardation institutions/units were identified as meeting criteria for community placement. In addition, currently 189 individuals are on Waiting Lists for institutional services and 1,995 individuals are on Waiting Lists for community-based services. (See Attachment 5, Mental Retardation Waiting Lists) Every year approximately 400 individuals graduate from special education classes in the Georgia school system and are in need of services. The crisis of capacity to meet these needs grows each year.

\* \* \*

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## **Expanding Georgia's Community Services**

### **Brook Run Closure**

**[Logo] DHR**

Georgia Department of Human Resources -  
Division of Mental Health Mental Retardation and  
Substance Abuse  
July, 1997

### **Expanding Georgia's Community Mental Retardation Services A plan to close Brook Run**

The Georgia Department of Human Resources (DHR) will expand community mental retardation services by closing Brook Run, a state institution in DeKalb County, state and Medicaid funds to serve the residents in new community programs, plus more than 200 people from the waiting list.

Brook Run serves 326 people from 37 counties in metro Atlanta and northeast and northwest Georgia. (See Attachment A for number of residents by region.) Most of the residents need 24-hour supervision and assistance with daily living but do not have special health care problems. More than 100 residents take part in workshops on campus: 22 hold regular jobs through supported employment; and 39 residents attend school, including 19 who go to schools off campus. Sixty-eight residents currently receive skilled care for their physical disabilities or special medical needs.

This plan describes the steps required to ensure that Brook Run's closure is smooth, that the residents and

others receive the services they need, and that all relocations are done carefully. The time frame for each activity may be found in Attachment B.

**Briefly, Brook Run's closure means:**

- 326 Brook Run residents will have an opportunity to move to new community services under the watchful eye of the state, advocates and a special oversight committee.
- Family members will be involved in planning their relative's new placement, and they will participate in a monitoring system to ensure their safety and well being.
- 206 people from the waiting list will receive community based services – 156 people in residential and day services and 50 people in supported employment.
- Brook Run residents who are medically complex and want continued hospital care will be moved to an upgraded unit at Georgia Regional Hospital in Atlanta or to another state operated facility closer to home.
- Residents from Georgia's other mental retardation facilities will have a chance for community services in place of Brook Run residents who choose continued hospital care.
- Temporary and immediate care beds will be maintained in the Atlanta area to help families during a crisis.
- Dental services will be maintained in the Atlanta area for those with critical needs

who cannot be served by community dentists.

- A monitoring system for community services will be strengthened.
- The costs of maintaining an aging facility will be eliminated.
- Brook Run's 489 classified employees will be considered for job openings at two state institutions in Atlanta. Many may find jobs in the new community services. Employees will be offered training to become certified nursing assistants, an occupation in high demand in metro Atlanta.
- The property will be turned over to the State Properties Commission for disposition after the last resident leaves.

**Why close an institution?**

At public forums and other meetings across the state, citizens with mental retardation, their families and other advocates have urged DHR to move away from institutional care toward more progressive and individualized services that allow people with mental retardation to become as independent as possible and to live more normal lives in their home communities. Advocates statewide support this shift for both humane and economic reasons.

**Quality of care** – More than 50 studies nationwide and our own experience in Georgia show that people with mental retardation who move from institutions to community services make dramatic gains. They learn a variety of daily living skills, have fewer behavior problems,



usually have more contact with their families and are more satisfied. Two years ago, DHR moved 64 people with severe and profound mental retardation from state institutions to community programs under the SH/PF class action law suit. Half of the residents could not walk: a large number had both mental illness and mental retardation. Only one person has been readmitted to a mental retardation institution. Most have made progress beyond families' and staffs' expectations.

**Growing waiting lists** – Georgia has nearly 2,000 people on waiting lists for community services, and the number grows by about 400 people each year. Only 189 families have requested institutional services. Many of the people on waiting lists are just as disabled as the residents at Brook Run. Some parents are elderly and growing frail. They are desperate to know what will happen to their grown children when they are no longer able to care for them. New state funding is not available to develop the services these families need. DHR must use existing dollars to expand community services.

**The real possibility of litigation** – If we do not begin to serve people on the waiting lists, Georgia will likely face a class-action law suit.

**Georgia's lack of progress** – Across the country, the number of people with mental retardation in institutions has dropped from 194,650 people in 1967 to 65,735 residents in 1994. Five states no longer operate any public institutions. In the past 20 years, the number of people receiving community residential services increased six fold. Georgia ranks near the bottom – 48th among states –

when it comes to funding services for people with mental retardation in the community.

**The high cost of institutional care** – The average cost to serve someone at Brook Run is \$267 per day; the cost in the community under the Home and Community-Based Waiver ranges from \$106 to \$181 per day for residential, day training and a range of support services. It costs more than \$3.3 million each year just to maintain Brook Run's buildings. The hospital residents who moved to the community two years ago under the SH/PF law suit cost, on the average, \$24,000 per person, per year less than it would cost to serve them at Brook Run. They are receiving the full range of services they need, and they are just as disabled as the Brook Run residents. Only one person has returned to an institution.

**DHR's obligation to close hospital beds** – Under the current "Home and Community Based Medicaid Waiver," DHR agreed to close 1,000 hospital beds; we have closed only 147. To continue using Medicaid funding for new community mental retardation services, we must close hospital beds and move the Medicaid money from the institution. Closing beds one at a time without closing a complete unit or hospital is not economical, because the infrastructure must be maintained for the residents who remain. When the same costs are spread among fewer residents, the per person costs increase dramatically.

**The FY '98 Budget Redirect** – As part of the Governor's plan to have state agencies "redirect existing state funds to develop or expand priority services, DHR is proposing to redirect over \$7 million from mental retardation institutions to community mental retardation services. To

achieve this funding, more than 300 hospital beds must close, and the closing must be consolidated in one institution.

### **Why close Brook Run?**

Brook Run is the right size to produce the funding needed, and it is a manageable size to close in the time frame required. It is the smaller of the two state institutions that serve only people with mental retardation. Gracewood State School and Hospital in Augusta has over 600 residents and would be more difficult to close. Four state psychiatric hospitals also have mental retardation units. Closing a unit would not produce the same funding because many of the hospital's fixed costs would continue.

A second reason for choosing Brook Run is its location. Metro Atlanta has more available housing to lease for residents, most of whom come from the Atlanta area. Atlanta has more job opportunities for staff, including vacancies at two other state facilities in DeKalb County. Also, many of the new community programs will be in the metro area. Closing Brook Run in Atlanta will not have the same economic impact as closing an institution in a small community.

Other options for Brook Run were considered, but were not feasible. The most stringent reduction in operating costs would save only 10 percent of the budget and would not produce the amount needed for the FY '98 Budget Redirect. Eighty-three percent of Brook Run's

budget is personnel costs. Significant reductions in personnel would jeopardize patient care, federal certification and the funds that are tied to it.

Privatizing Brook Run is not the answer. The legislation passed in 1993 to reform the public mental health, mental retardation and substance abuse service system contained some safeguards for current employees to prevent them from losing their jobs as a result of privatization. Again, because 83 percent of Brook Run's cost is personnel, a private company would not be able to save money as long as it must keep the same staff at the same salaries.

Quality of care had nothing to do with choosing Brook Run for closure. Brook Run recently received Accreditation with Commendation from the Joint Commission on Accreditation of Healthcare Organizations. All of Georgia's state institutions received JCAHO accreditation during the same survey period.

The decision on Brook Run is more far reaching than the facility's future. It is a policy decision about the future of Georgia's public mental retardation services. Rather than relying on costly, "one size fits all" institutional care, we will move forward by expanding more individualized community services that offer a better quality of life.

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Thursday, Nov. 20, 1997, p. F3,  
The Atlanta Journal/The Atlanta Constitution

### State urging leaner mental hospitals

**Money troubles:** Cost-cutting effort leads to proposed incentive for reducing in-patient care at state's psychiatric facilities.

**By Christy Oglesby**

STAFF WRITER

State officials are proposing a financial incentive to try to get more people out of state-run psychiatric hospitals and into community-based programs.

Under the proposal, the regional medical boards that govern the state's psychiatric hospitals will be allowed to spend more money on community-based programs if they reduce the amount of time patients spend in hospitals.

The budgeting adjustment is the latest development in an effort that began four years ago to cut costs by downsizing and consolidating hospital services.

Board members of the Department of Human Resources will vote next month on the proposal and other recommendations to continue streamlining.

"We need to promote the downsizing for two reasons," said Eddie Roland, director of the division of Mental Health, Mental Retardation and Substance Abuse of DHR. "First is the cost of in-patient care and the overhead. The second reason is we find for most consumers that they do far better and are able to be more productive" in community settings.

Currently, regional medical boards are permitted to spend 10 percent of their money on community-based

psychiatric services provided in counseling offices, group homes and other arrangements. Under the new proposal, boards would be able to spend 15 percent of their budgets on such services. As a result of spending less on hospital care, the boards would have more money to spend on outpatient services.

Mental health advocates have supported the state's effort to move people out of institutions and place them in living conditions that teach independence.

Since the mental health division started its downsizing plan in 1993, hospital use has dropped by 27.8 percent, or 580 beds, and \$29.5 million saved as a result has gone into community services.

Additionally, two mental retardation facilities – Brook Run in Dunwoody and River's Crossing in Athens – have closed. In the spring, DHR will ask legislators to approve the closure of the Georgia Mental Health Institute, a psychiatric hospital on Briarcliff Road.

Hospital consolidation plans in Augusta and Middle Georgia are under way. Mental health hospitals in Mill-  
edgeville, Savannah and Columbus will share one chief operating officer as well as some departments such as personnel, purchasing and billing. As the shrinking continues, the board must deal with the politics of economics and employment, Roland said.

Georgia employs about 9,000 people at its remaining eight mental health hospitals and one mental retardation facility.

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UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

ORDER

(Filed Oct. 20, 1998)

This action is before the Court on plaintiffs' motion in limine on remand. For the following reasons, the Court grants the motion.

The court of appeals remanded this case for further proceedings on the issue of whether requiring the State to make additional expenditures in order to provide plaintiffs L.C. and E.W. with integrated services "would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides." *L.C. by Zimring v. Olmstead*, 138 F.3d 893, 905 (11th Cir. 1998). A hearing on this issue is scheduled for October 29, 1998.

Plaintiffs seek an order *in limine* limiting the evidence at the hearing to the impact of additional expenditures, if any, required to serve the two plaintiffs in this case and excluding evidence regarding the possible future impact of the court of appeals' decision on other individuals. Defendants, on the other hand, seek to adduce evidence at the hearing as to the State's overall care-delivery system for all mentally disabled persons. The Court concludes that only evidence regarding additional expenditures for the two plaintiffs in this action is relevant to the issue on remand.

The court of appeals' decision is quite clear that the issue to be decided on remand relates to the provision of integrated services only to L.C. and E.W. *L.C. by Zimring v. Olmstead*, 138 F.3d at 905 ("The district court did not consider whether *treating* L.C. and E.W. would require additional expenditures and if so, whether the State had met its burden of proving that those expenditures were unreasonable in light of the State's mental health budget") (emphasis supplied)). The court of appeals specifically noted that "this case is not a class action, but a challenge brought on behalf of two individual plaintiffs. Our holding is not meant to resolve the more difficult questions of fundamental alteration that might be present in a class action suit seeking deinstitutionalization of a state hospital." *Id.* at 905 n.10.

Thus, the only issue before the Court on remand is whether, given the demands of the State's mental health budget, any additional expenditures required to treat L.C. and E.W. in community-based programs would be so unreasonable as to fundamentally alter the service the State provided. Evidence regarding the impact the decision in this case may have beyond L.C. and E.W. is irrelevant to this issue.

Accordingly, the Court GRANTS plaintiffs' motion in limine on remand [#104-1].

IT IS SO ORDERED, this 19th day of October, 1998.

/s/ Marvin H. Shoob  
Marvin H. Shoob, Senior Judge  
United States District Court  
Northern District of Georgia



## Opening the Gateway to the Future

[Pictures Omitted In Printing]

### 1997 ANNUAL REPORT

Georgia Department of Human Resources  
Division of Mental Health, Mental Retardation and Substance Abuse

### AN OPEN LETTER

By LARRY FRICKS

\* \* \*

Governments that muzzle the empowerment of individuals and natural supports of communities are destined to fail. And among society's most muzzled populations has been people with disabilities. Since the Georgia State Lunatic Asylum opened in 1843, and all across this country, we built a system of services focusing on people's disability rather than their potential. Stigma forced that national philosophy. Thus, we were locked away.

\* \* \*

[Pictures Omitted In Printing]

### DOING FOR THEMSELVES

*From top to bottom, Christine Gomez, Randy Jones and Nydia Brumfield are Georgians "doing for themselves" with the help of services like job placement, supported living, and a drug treatment program.*

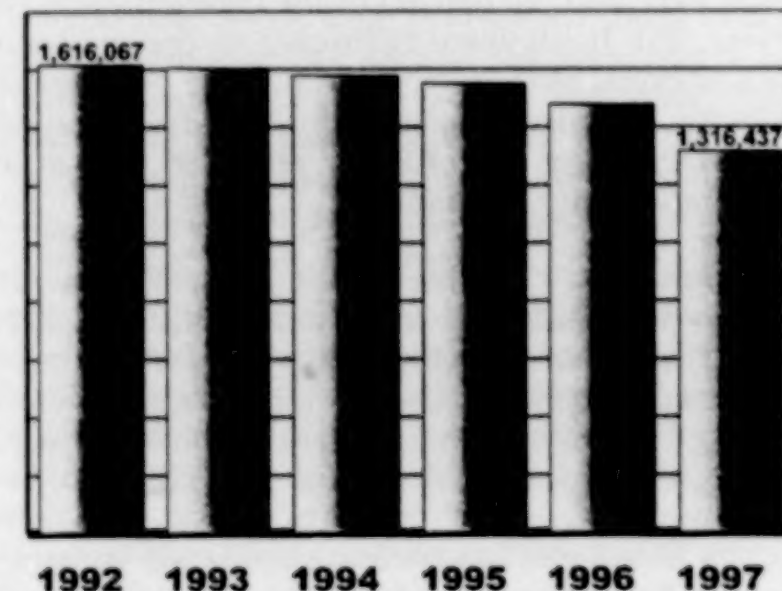
### Reduced Hospital Use: Expanding Community Services by "Redirecting the Dollars"

The impact of the MHMRSA Reform, a need to serve more with less, an increasing demand for service, the

availability of new more effective psychotropic medications, and new approaches to community treatment and support put the Division on a course of action that supported hundreds of people to live more successfully in community settings and reduce the need for hospital services. The reduction in hospital services resulted in a significant increase in community services.

### All State Hospitals Days of Hospital Care

(For A 19% Reduction Over Period)



### 1997 Highlights and Accomplishments

- Fiscal year 1997 was the first year that funds were transferred using the hospital allocation formula. The formula is a method by which regions with reduced hospital use can transfer funds from hospitals to community services.
- Fiscal year 1997 was also the first year of the Governor's budget redirection effort which allows funds to be transferred or "redirected" to reflect new priorities

and changing needs. The process was consistent and supportive of existing strategic plans to move hospital funds to community services.

- Hospital admissions declined by 30 percent, which made possible the elimination of 500 beds system-wide.
- There has been a dramatic decrease in hospital services for children and adolescents with severe emotional disturbance (SED). Since Fiscal year 1992 the days of hospital care have declined 42 percent. In Fiscal year 1997, 50 percent of the inpatient beds were closed. The funds were redirected to the community for additional SED services at only half of the needed capacity. DHR has requested that services be funded statewide by the end of Fiscal year 1999, still at only half the capacity needed.
- There has been a similar decline in inpatient hospital services for adults with chronic mental illness (CMI). Since Fiscal year 1992 the days of hospital care have decreased 26 percent from 751,047 days to 556,355. Almost \$30 million has been redirected from the hospital system to the community. The Division has a multi-year plan to add funding for specialized community based services for this population in targeted areas of the state each year. DHR has requested that services be funded statewide by the end of Fiscal year 1999.
- During 1996, the alcohol and drug unit at Georgia Mental Health Institute (GMHI) was closed. Funding for this unit was redirected to community substance abuse services in the four regions of the state that are served by GMHI. With the closing of this unit, the MHMRSA system no longer operates hospital based units for substance abuse services.

- Rivers Crossing, a 37 bed facility in Athens, was the first mental retardation institution to be closed in Georgia. Since Fiscal year 1994 various units in other facilities including Southwestern State Hospital have also closed. A total of 147 institutional beds were closed in these facilities.

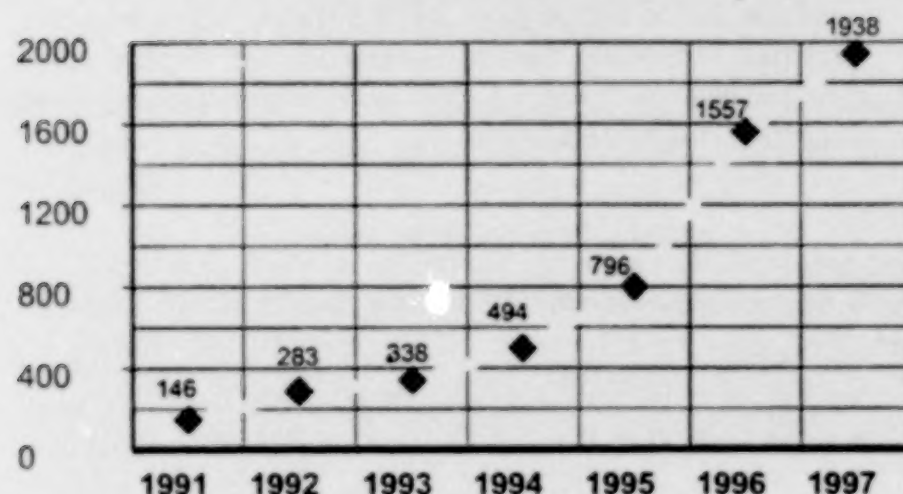
[Picture Omitted In Printing]

*Brook Run mental retardation facility, below, closed in 1997.*

- The closure of Brook Run, left, a large mental retardation facility in Atlanta, transferred 326 persons with mental retardation from institutional beds to community placements. As part of the Governor's budget redirections, \$15 million will be redirected from the institution to expand community services. An additional 206 people who are on waiting lists or graduating from special education classes will be able to receive community services.
- The Medicaid Home and Community Based Waiver has funded many more people with mental retardation to live in the community. The waiver allows the use of federal Medicaid funds in the community instead of institutions. It also "stretches" state dollars; for every \$1 of state funds, Medicaid pays almost \$2 toward the cost of services. A statewide agreement among regions allows these funds to follow the consumer anywhere in the state. In Fiscal year 1997, the waiver served 1,938 people statewide.



### Total Consumers: Mental Retardation Waiver Program



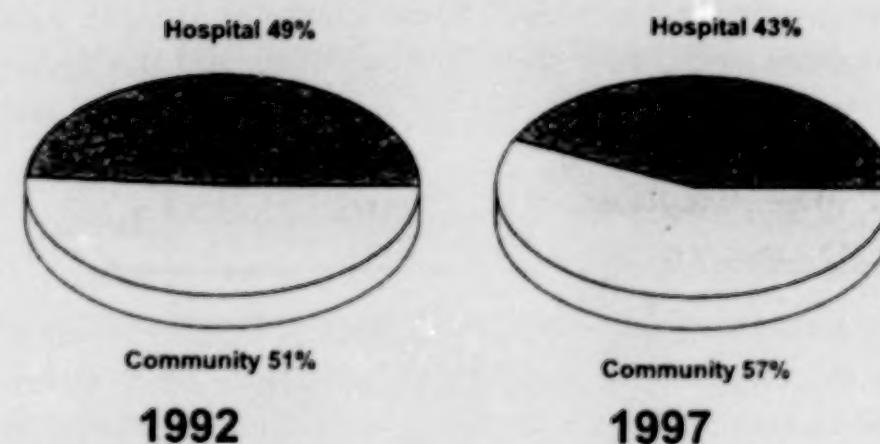
#### Trends

The Division's Reform has opened the door for reducing dependence on hospital services by enhancing community service. Funds now follow the consumer, and community services continue to grow as the need for hospital services decreases. This trend is expected to continue. Note the relationship between hospital use reduction and the growth of community services as well as anticipated changes highlighted in this section.

[Picture Omitted In Printing]

*Melissa Holmes enjoys cooking in her supportive living apartment.*

### Where Clients Are Served By Expenditure, 1992 vs. 1997



#### Future Directions

As consumers are served closer to home by enhanced community services, there will be a decreased need for hospital beds for all MHMRSA disabilities. The need for fewer hospital beds will result in a smaller hospital system. Plans to consolidate administrative and patient support services were developed for Atlanta Regional and Georgia Mental Health Institute, Augusta Regional and Gracewood, as well as Central State Hospital, West Central Georgia Regional Hospital, and Savannah Regional Hospital. The DHR Board has proposed the closure of the first mental health hospital, Georgia Mental Health Institute in Atlanta. Plans are underway to evaluate and plan for the future capacity, location and cost of state hospital services.

**The state hospitals that remain open will have new or additional roles in providing services to consumers.** State hospitals are already going beyond their walls to set up assertive community treatment teams and other services to help people live in the community and avoid repeated

hospitalizations. In order to compete in the new environment, hospitals are also implementing "Best Clinical and Administrative Practices." Some examples include new processes to measure treatment outcomes and the development of a consistent set of service descriptions and costs.

### Community Living

Reduction in the use of hospital beds is a direct result of the development of supported community alternatives. This is especially true for individuals who have lived in hospitals for many years and now have the opportunity to live in the community. The growth of residential services in the community as well as the range of service options is highlighted in this section.

[Picture Omitted In Printing]

*Home manager Phyllis Turner, left, reviews the household plans with Melissa Holmes.*

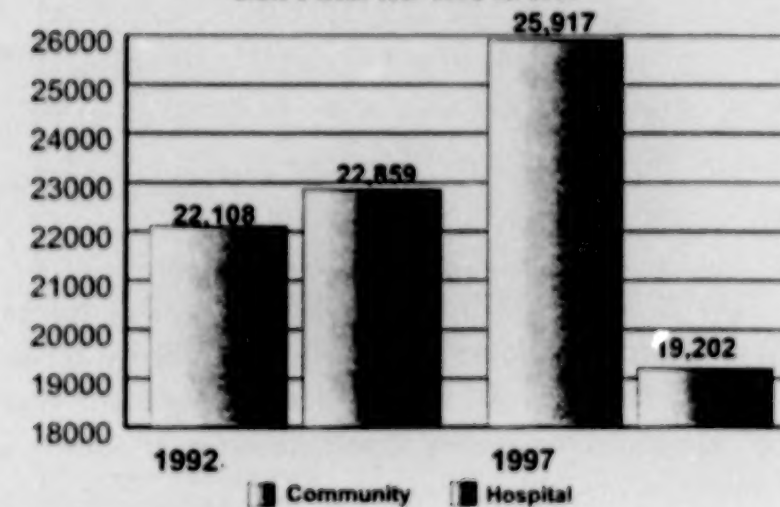
### 1997 Highlights and Accomplishments

- In Fiscal year 1997, 35 percent more consumers received residential services in community settings than in hospitals. In Fiscal year 1992 approximately the same number of consumers resided in the hospitals as in the community.
- Regional boards are beginning to fund a new generation of services including mobile crisis services, assertive community treatment teams, wraparound services for children, family support and respite services, new more effective medications, supported

employment and supported housing. There has also been an increase in community based emergency receiving facilities.

### Total Served: Community Residential vs. Hospital Services

State Fiscal Year 1992 vs. 1997



[Picture Omitted In Printing]

*Betsy Goodrich is living in her community and enjoys the pace of the workplace.*

- That all people should be supported to live in the community has long been a value prized by consumers, direct service staff and advocates. During the system reform, consumers demanded and professionals agreed that we need to learn more about how to support people and that their potential for independence/self-sufficiency has far exceeded earlier assumptions.



## A Call For Resolve:

### *Fulfilling Our Promise*

to Consumers, Families, and Communities

*Final Report of*

The state commission on  
Mental Health, Mental Retardation,  
and Substance Abuse Service Delivery

### Promising Trends

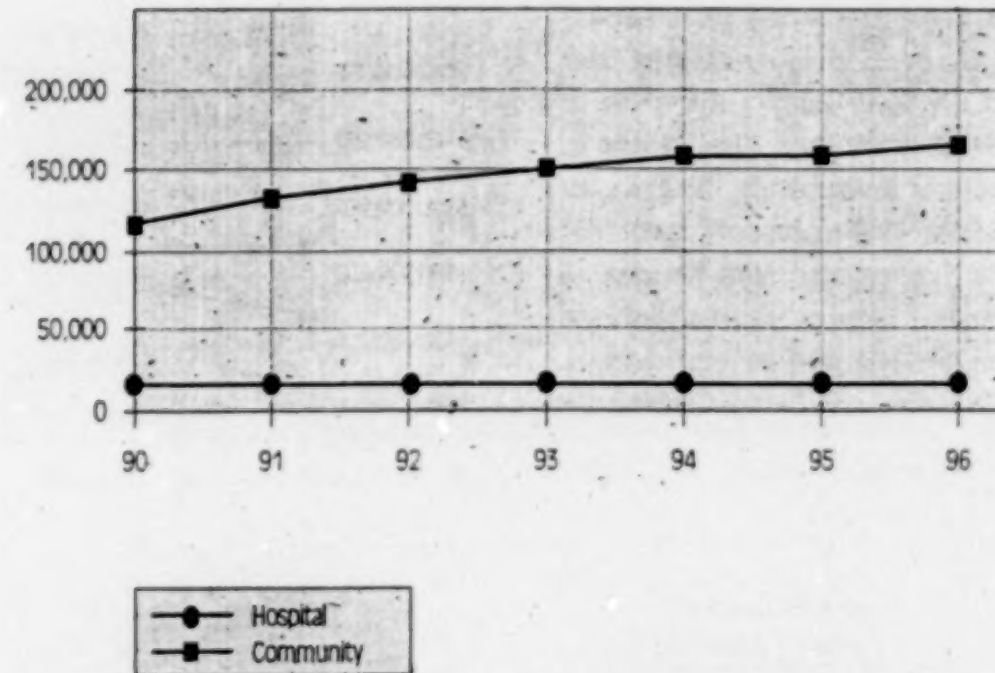
\* \* \*

**Note:** This is an unduplicated count. Hospital refers to "Hospital Residential Services" and Community refers to "Community Services All Modalities". "Medicaid Waiver Service" accounts for a very small number of clients and is not included in this chart.

This chart shows a flat Hospital line over the 7-year period at around 24,000 clients. Community Services steadily climb during this same time period, reaching more than 150,000 clients served in 1994 and continues upward to current high of 165,239. Thus, the overall growth in clients served has occurred in Community Programs and not in Hospitals.

**CHART 1**

Number of Clients in Hospitals and Community Services: SFY 1990-96

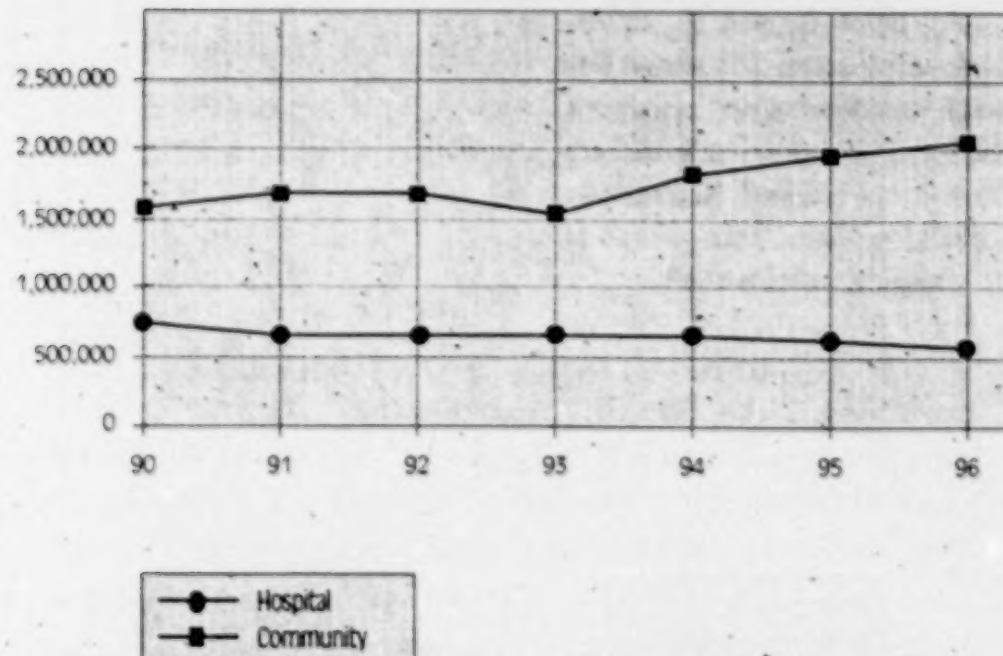


**Note:** Hospital refers to "Hospital Residential DACE" and Community refers to "Community Residential DACE".

This chart shows a decline in Hospital DACE over the 7-year period from 727,146 to 551,819. Community DACE is relatively flat for the first few years, then beginning in 1994, steadily increases reaching over 2 million in 1996. These data demonstrate that the growth in DACE is occurring in community-based programs and not in hospital settings.

**CHART 2**

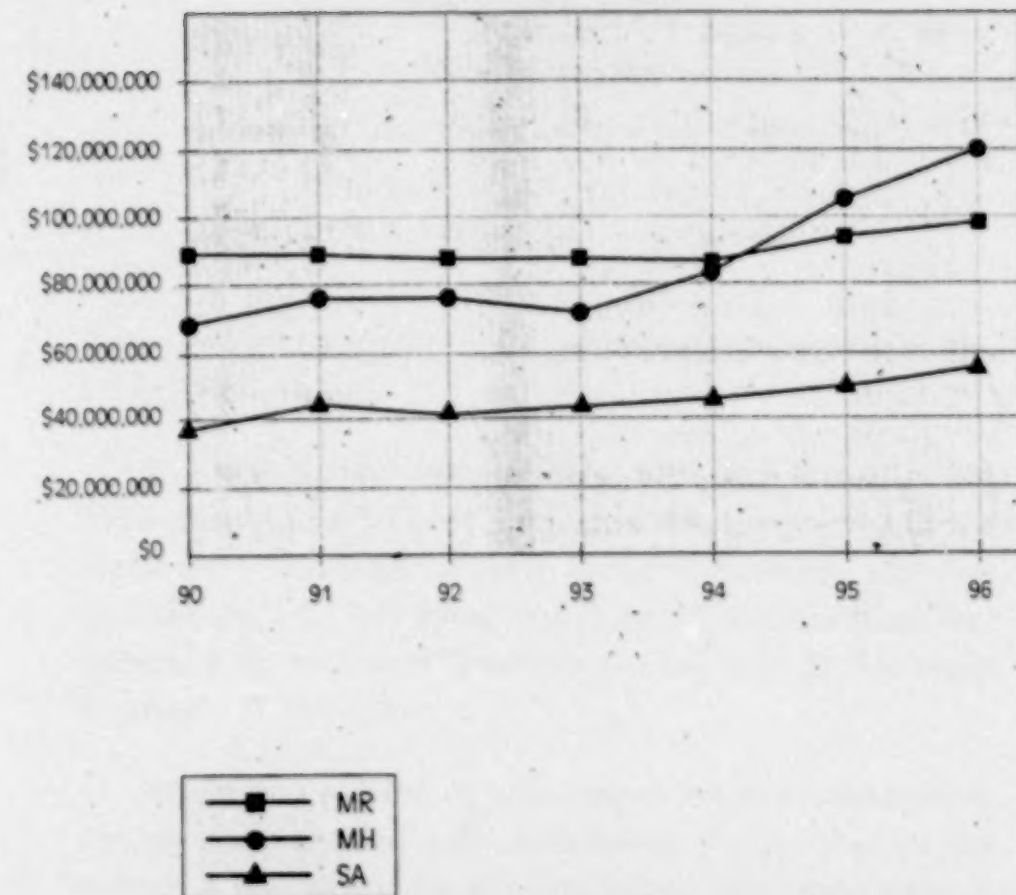
Number of Days Active Client Enrollment (DACE) in Hospital and Community Residential Services: SFY 1990-96



**Note:** Includes federal and state funds received by Georgia Department of Human Resources (DHR). This chart does not include Department of Medical Assistance state and federal funds. MH refers to "Mental Health", MR refers to "Mental Retardation", and SA refers to "Substance Abuse". SFY 1997 is not included because of transfer of state funds to Medicaid for the MR waiver conversions. DMA state and federal dollars are not reflected in this chart.

**CHART 3**

DHR Funds Available for Community Programs:



This chart shows fund availability to be fairly flat from SFY 1990 through 1993, and then increasing steadily from SFY 1993 through 1996. Mental Health, in particular, has a substantial increase beginning in 1994. Substance Abuse experiences an infusion of funds in SFY 1991; bring it above \$40 million and then remains steadily until 1995 when it raises to \$50 million and reaches nearly \$55 million in 1996. Growth in funding for Mental Retardation has also occurred through leveraging state dollars



through the Mental Retardation Waiver Program. This growth is not illustrated in this chart.

\* \* \*

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*Hospital Resources*

*Allocation Task Force*

*FINAL REPORT*

*November 1997*

*Georgia Department of Human Resources*

*Division of Mental Health,  
Mental Retardation and Substance Abuse*

\* \* \*

SUMMARY – IMPACT OF HOSPITAL FORMULA ON  
PURPOSES 1 AND 2

The implementation of the hospital formula did indeed have a significant impact on the downsizing of the eight state hospitals, as well as fostering more effective application of CMI funding. Hospital downsizing was sufficient to seriously consider closing one of the eight hospitals at this time.

While downsizing of public agencies or institutions is always accompanied with difficulties, the process for the hospitals was relatively systematic and free from crisis. A unique feature of the formula required each region to purchase hospital inpatient services at 90% of the magnitude experienced two fiscal years earlier (unless its Fair Share was less than this amount), whether the region needed this level of service or not. If a region's Fair Share is less than the 90% of its hospital budget, it is required to apply the entire Fair Share to the purchase of hospital services. Thus, the hospitals had only to reduce operations of the applicable adult MH/SA cost centers for each of the two fiscal years that the formula has been in effect

at a rate that is approximately ten percent of the operational level experienced two fiscal years previously. Amazingly, only one hospital had to exercise a reduction-in-force (RIF) during FY 1997 and one hospital in FY 1998. The other hospitals apparently were able to make the necessary adjustments through employee attrition and other organizational modifications.

This reduced dependence of the regions on hospital inpatient services could not have been realized if the regions had not been provided significant control over the funds for the impacted adult MH/SA hospital cost centers. Thus, Purpose 1 – shift of control of hospital funds from hospitals to the regional boards – must be viewed as successful.

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# **THE PATH AHEAD**

## **A Two Year Plan of the Department of Human Resources Division of Mental Health, Mental Retardation and Substance Abuse**

**June 1997**

\* \* \*

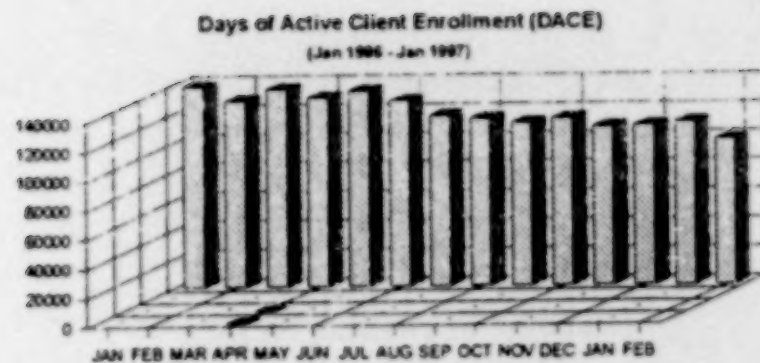
Too often they are inappropriately housed in state hospitals, jails, nursing homes or at home with a family that is financially and emotionally exhausted. Some end up on the street. Approximately 264,000 Georgians suffer from serious mental illnesses such as schizophrenia, major depression and manic depression. Many go unserved until a major crisis occurs. Costly state hospital care is often the result when community services do not exist.

\* \* \*

### **Reducing Hospital Use**

- A comparison of days of active client enrollment (DACE) in the hospitals from January 1996 to January 1997 reveals declining hospital use. This comparison shows a 20 percent decrease in the use of hospitals.





- Persons with mental retardation are moving from mental retardation institutions back to their communities. Since the passage of HB 100, 147 institutional beds for persons with mental retardation have closed.

\* \* \*

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF CARROLL D. BENSON

\* \* \*

2.

I am the Director of the Monitoring and Evaluation Section of the Division of Mental Health, Mental Retardation and Substance Abuse ("MHMRSA") of the Georgia Department of Human Resources ("DHR"). I manage the Division's program evaluation process, performance evaluation measurement, provider certification, legal and risk management, consumer rights, consumer advocacy, licensure activities, the Behavioral Health Data Center, and investigations. I have a Masters of Education degree in Rehabilitation Counseling.

3.

In my position as Director of the Monitoring and Evaluation Section, I was familiar with the cases of L.C. and E.W., and, ultimately, their placement in the community. I have also read the order of the Court of Appeals in this case, as well as the First Affidavit of Carl E. Roland. I believe that the order is very ambiguous in some regards. However, it suggests an approach to the provision of services for the mentally disabled that is fundamentally different from the provision of these services in Georgia today.

## 4.

First, the order seems to rely entirely on the Department of Justice's current interpretation of the "Integration Regulation" as the one-and-only principle that should guide Georgia's programs. This ignores Georgia's system of governance that has been carefully developed since the reform legislation of 1993.

## 5.

Prior to 1993, the governance, funding, and management of the system created a service delivery system that was called "a patchwork of programs stitched together over time" that has "left gaps and shortcomings in the system." (See Attachment A, which is a true and correct copy of the Report of the State Commission on Mental Health, Mental Retardation, and Substance Abuse Services Delivery, Atlanta, Georgia, 12-1-92, p. 1.)

## 6.

The State Commission on Mental Health, Mental Retardation, and Substance Abuse Services Delivery (the "Commission") was established for the purpose of "developing a comprehensive plan for an improved services delivery system for the treatment and habilitation of people with mental illness, mental retardation and substance abuse problems. . . ." (Attachment A, Report of State Commission, p. 3).

## 7.

The Commission developed a set of guiding principles to be used as they talked about system change and design. These principles have become a way to organize the implementation of the reform, and they still guide our ongoing work.

## 8.

I believe that the Court of Appeals' order fundamentally alters these principles. These principles are listed on pages 11 and 12 of the Report. Three of the key principles which appear to be in most conflict with the order are as follows:

## 9.

**CONSUMER CHOICE.** The Commission's first principle is consumer choice: "Consumers and families shall have choices about who the service providers are by having input in planning the service system, and which services will be provided by being involved in the development of their individualized service plans." The Court of Appeals' order, however, requires the "most integrated setting appropriate" *according to the professionals*. The order appears to be in direct conflict with the Commission's principle.

There are times when the consumer's choice is not the community, but a facility. For example, when Brook Run, an Intermediate Care Facility for the Mentally Retarded ("ICF-MR") was closed in December 1997, over



a hundred individuals chose to continue to receive services in an ICF-MR rather than in a community placement.

Arguably, if the Court of Appeals' standard of requiring the most integrated setting had been followed, it would not have been possible to give these consumers a choice, since many of them "could" have been placed in the community with adequate support.

## 10.

**MOST IN NEED.** The Commission Report adopted a "most in need" principle to guide the allocation of scarce resources: "Given that there will never be sufficient resources to meet the total need for people with mental illness, mental retardation and substance abuse problems, public funds shall be allocated to ensure the needs of consumers who are most in need are met at the appropriate service levels."

For example, a Region may decide that a person in the community who is receiving no services and whose parents have become ill is "most in need," compared to another person in an institution who is receiving services. The Court of Appeals' order appears to severely limit or destroy a Region's ability to make this type of allocation, since the order may be interpreted to require the State to serve the institutionalized person first.

## 11.

**QUALITY OF SERVICE.** Another of the Commission's principles is that the "system shall be designed to

provide the highest quality services utilizing flexibility in funds and incentives which reinforce quality and efficiency." However, the Court of Appeals' order does not seem to provide such flexibility.

First, the order may require the "most integrated" treatment in lieu of the "best quality" treatment. There are times when a consumer can be appropriately treated in the community, but the treatment that can be provided in the institution is of better quality.

Also, "flexibility in funds and incentives which reinforce quality and efficiency" allow the cost to be considered. Although it is *generally* true that it is cheaper to treat a person in the community rather than in a facility, this is by no means always the case. It will often be significantly cheaper to serve a medically fragile person or a person with complex behavior in a facility rather than in a community.

## 12.

These are three of the most important principles of the Commission that conflict with the order. I believe that the entire approach of the Court of Appeals is fundamentally different from Georgia's approach.

## 13.

It should be noted that the Commission's recommendations, published in December 1992, were profoundly and effectively supported in the State. In April 1993, the Georgia legislature passed a sweeping reform of the MHMRSA service system. House Bill 100 created the

framework for a new public service system with more local planning and decision-making from consumers and family members. (See Attachment B, which is a true and correct copy of the 1997 Annual Report, Georgia Department of Human Resources, Division of MHMRSA, "Reform of the System," p. 7; Attachment C, a true and correct copy of the Final Report of the State Commission).

14.

One result of the reform has been the planned and systematic reduction in hospital services. Hospital admissions declined by 30 percent. The patient-days of hospital care declined by 19 percent. Five hundred hospital beds were eliminated system-wide. (Attachment B, 1997 Annual Report, p. 13.) Brook Run was closed in December 1997, and the Georgia Mental Health Institute was closed June 30, 1998.

15.

At the same time, the number of persons who received community residential service has increased, from 22,108 in 1992, to 25,917 in 1997. (Attachment B, 1997 Annual Report, p. 17). The number of persons funded on a Medicaid Home and Community Based Waiver has increased from 283 in 1992, to 1,938 in 1997. (Attachment B, 1997 Annual Report, p. 15).

16.

The percentage of community funding has changed from 51% of the total of community and hospital funding

in 1992, to 57% in 1997. (Attachment B, 1997 Annual Report, p. 16).

17.

It was through the reform described above that it was possible to place L.C. and E.W. in the community, as funding became available and, in regard to E.W., after her serious medical condition was surgically and medically treated. Fiscal incentives and management have been key in accomplishing these results. (See Attachment D, a true and correct copy of the Hospital Resources Allocation Task Force: Final Report, November 1997; see also, Attachment E, a true and correct copy of the 1997 Two Year Plan).

18.

The Court of Appeals' order states that the State must spend additional funds to place L.C. and E.W. in the community unless it would be so unreasonable that it would fundamentally alter the services the State provides. *L.C. and E.W. v. Olmstead*, 138 F.3d 893, 905 (11th Cir. 1998). Of course, it is unlikely that services for any two individuals will cause a fundamental alteration, given that the State provided residential services for over 45,000 persons in 1997. (Attachment B, 1997 Annual Report, p. 17). However, the provision of services in the manner envisioned by the Court of Appeals *would* be a fundamental alteration, and it ultimately would cause a fundamental alteration in Georgia's programs and services.



19.

It is impossible to calculate how many consumers "could" be served in the community, according to the experts, given unlimited funding to provide adequate support in the community. However, there are approximately 1900 persons on the waiting list for services, and provision of these services would be likely to cost \$100,000,000. Some additional numbers of the individuals currently being served in hospitals (potentially all of them, as stated by Mr. Roland in his first affidavit) could also be moved to the community, with the closure of some or all of the State's hospitals and the expenditure of additional funds.

20.

Finally, the Court's Order would interfere with the discretion and authority of the Regional Boards to plan, purchase, and contract for community and hospital services, as was explicitly called for by the State Commission and mandated by the 1993 legislation. The Court's order shifts the locus of control away from the local communities and towards the individual patients' treating professionals alone.

FURTHER AFFIANT SAYETH NOT.

/s/ Carroll D. Benson  
CARROLL D. BENSON

Sworn to and subscribed  
before me this 29th day  
of October, 1998.

/s/ Linda Joyce Parker  
NOTARY PUBLIC

My commission expires:

Notary Public, Clayton County, Georgia  
My Commission Expires April 7, 2001

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## DEPOSITION EXCERPTS:

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF GEORGIA  
ATLANTA DIVISION

L.C., by JONATHAN ZIMRING       )  
as Guardian Ad Litem & N/F       )  
  vs.       )  
TOMMY OLMSTEAD,                    )  
Commissioner, et al.                )

THE DEPOSITION OF DR. RAMESH N. AMIN.

\* \* \*

DECEMBER 13, 1995.

\* \* \*

[p. 94] Q Yes, but can she make the same degree of progress in the hospital that she can make in the community?

A No, not the same degree.

\* \* \*

\_\_\_\_\_

THE DEPOSITION OF DR. DILPIKUMAR PATEL.

\* \* \*

DECEMBER 13, 1995.

\* \* \*

[p. 101] Q Okay. So before the mother became an option, you were thinking of - please tell me if I said it right - a 24-hour residential home life and a day program like CFI or perhaps something more intense.

A In combination with other structured placement. If you go with the programming treatment needs, then you have the obstructed placement or the residential. Or if you have alternative to that, if you have a residential treatment program for her that is in your favor.

Q But you never - it is true you were never able to locate this kind of program?

A No.

\* \* \*

[p. 123] Q If there her [sic] been a structured placement, in you [sic] opinion would that have been appropriate at that time, if something had been available?

A Yes.

Q Was it your decision that she be transferred [sic] to Brook Run?

A My decision?

Q Yes.

A No.



Q Do you know who made that decision?

A My opinion, personal opinion, it wasn't me. I am observing what I have stated at that point, patient seems to have need for a place to stay -

Q And is it correct that because there was no community structured place, Brook Run was the only alternative?

A That was my understanding.

\* \* \*

[p. 150] Q January of '94.

A January 4. Okay.

\* \* \*

A Patient seems to be at a functional level and on the date of that visit, does not talk about delusions, though occasionally she is seen as delusional and is able to maintain her NDL's most of the time. Periodically does require reminder. No change in mental status.

Q Okay. Does that reflect your opinion of her at that time?

A Yes.

\* \* \*

[p. 151] Q Is that - again, is that saying that for this particular patient she has basically achieved her level of functioning in that area?

A Yes.

Q Would it be correct to say that at this point, clinically you would want to maintain her at this level, would that be correct?

A Yes.

Q Could she be maintained at this level, in your opinion, in the community, in a structured community setting?

A Yes.

\* \* \*

---

DEPOSITION OF CHARLES B HOPKINS.

\* \* \*

JANUARY 10, 1996.

\* \* \*

[p. 31] A The legislature can appropriate money directly to the Department of Medical Assistance for the mental retardation waiver, and that is - that happens to some extent every year.

In addition to that, regions - the regions can request that some of their existing dollars be moved - be reduced and moved to the Department of Medical Assistance as match for additional people to go into the waiver.

\* \* \*

## DEPOSITION OF TOMMY OLMSTEAD.

\* \* \*

JANUARY 30, 1996

\* \* \*

[p. 51] A My concern as the Commissioner is that they operate and fulfill their mission as efficiently as possible, serving - giving the necessary service to the appropriate patients.

Q Could I interpret that to mean that perhaps they could be reduced in size and then still fulfill that mission?

A Yes, they could be.

\* \* \*

---

## DEPOSITION OF JIMMIE L. PARRISH, JR.

\* \* \*

MARCH 11, 1996.

\* \* \*

[p. 94] Q Okay. Did the team decide to discharge E.W. to a shelter?

A Because she refuses, after refusing treatment or other placement, yes.

\* \* \*

[p. 96] Q You think that was an appropriate decision based on the circumstances at the time to discharge her to a shelter? Is that what you're saying?

A No, I'm not.

Q Then was it an inappropriate decision?

A If we acted on it, I would say yes, it was an inappropriate decision. But we never acted on it, so I can't say it was so inappropriate, because we never made the discharge to the shelter.

Q I'm just asking you whether the decision was appropriate or inappropriate. I understand she was never actually discharge to the shelter. But you did testify that your team made a decision to discharge her to a shelter.

A Uh-huh.

[p. 97] Q Speaking today, in your opinion, was that an inappropriate decision?

A Yes.

\* \* \*

---



## DEPOSITION OF DILIPKUMAR PATEL.

\* \* \*

MARCH 12, 1996.

\* \* \*

[p. 25] Q So based on her choice then, she's appropriate to maintain in the hospital. You also felt that she could have been treated as an outpatient at that point?

A Yes. Personality disorder per se does not require hospitalization because that's a changed long-term pattern of behavior, unless there are crises.

\* \* \*

[p. 26] Q What sort of treatment would have been appropriate for her in the community at this time? Assuming she had chosen to be treated in the community, what sort of treatment would that have required?

A What sort of treatment?

Q Yeah, what sort of treatment and what sort of placement would that have required?

A Same kind of treatment that she would require for change of her behavior in the hospital.

Q And what kind of - what kind of treatment was that?

A Outpatient mental health follow up.

Q Are their providers capable of providing that treatment to her in the community?

A Majority of the personality disorders are treated in the community.

Q Okay. Since she elected to stay in the hospital or since at some point - well, why - what happened to change her mind that she stayed in [p. 27] the hospital?

A I believe Ms. Jamieson had intervened at that time to halt the discharge to the shelter.

\* \* \*

[p. 32] A One thing is that she has personality disorder; which as I said, so much that requires a change from the patient, not so much in terms of effective intervention. And keeping a patient in the hospital to make a change in the personality may not be the best structure to treat. She can still continue to get the treatment and change in the personality as an outpatient.

Q And in some ways is the community a better place for treatment?

A For the change in the personality, I don't see - unless there's a crisis - she requires to be in the hospital. I don't say it's better, but I think it's less restrictive than the hospital.

Q Right. And is that the goal of treatment, to get people into the less restrictive environment?

A Less restrictive, yes.

\* \* \*

Q Coming up to the current time period, [p. 33] do you feel EW could be treated in the community at this point still?

A She has difficulty with physical problems at this time. And if that is addressed, I think she could be treated in the community.

\* \* \*

[p. 75] Q Have you explored any placement options with EW or have you discussed any placement options with her other than personal care homes?

A No, I have not.

Q She has these behavioral problems, and I think that's one of the things that was noted on the master treatment plan was the long-term institutionalization. Would you agree that it's better to address those problems in the community than in the hospital?

A It's a long-term problem. It could be addressed in community. But I don't know whether you can call it addressed better in community. No, I think it can be fully good addressed in either outpatient or inpatient. Preferably, from the cost containment point of view, I think it could be addressed better in the community.

\* \* \*

[p. 76] Q If you were aware of a provider who could meet - who [p. 77] could meet her needs in the community, would you be in favor of placing her in the community?

A Yes; why not?

\* \* \*

\_\_\_\_\_

# DEPOSITION OF DR. GARY DEBACHER.

\* \* \*

MARCH 12, 1996.

\* \* \*

[p. 27] Q Right. What would have been a suitable placement for her in the community?

A Well, I would say - as I said, a group home for upper level mentally retarded people with or without some degree of mental illness, with strong staffing and with available day programs, including you know, some vocational activities, treatment activities if necessary.

\* \* \*

[p. 46] Q If you had a home provider who said they would be willing to take her, do you think it would be a good idea to give her a try in the community?

A You mean a staffed group home or just an individual provider?

Q A staffed group home that can provide the things you indicated a group home should do.

A Sure, yeah.

Q At what point do you think it would have been good to try that?

A Well, as soon as we would have known about such a place and had maybe about a month to prepare to, you know, based on her current situation and let her see the place; let them get to know her; talk about contingencies; trial visit her there for a while; you know, give her some encouragement for doing okay.



Q Okay, so any time with a month lead time or so after that April meeting, if you had known [p. 47] about a placement -

A Not after the April meeting. I think maybe - I think it's conceivable that later on there were times when we could have - with a month's lead time, we could have planned and tried that.

Q By the end of the Summer?

A Yeah.

\* \* \*

---

DEPOSITION OF

DR. RICHARD L. ELLIOTT, M.D., PH.D.

\* \* \*

APRIL 9, 1996.

\* \* \*

[p. 99] Long hospitalizations, frequent hospitalizations are the wrong kind of treatment for somebody with a borderline personality disorder or with whatever you want to call the [p. 100] kind of behavior problems she had. Because these frequent hospitalizations lead to regression and poor outcome, which is what they're seeing.

\* \* \*

DEPOSITION OF CHARLES WILLIAM BLISS.

\* \* \*

MAY 10, 1996.

\* \* \*

[p. 85] A I don't know. We review the results with E.W. and her mother each time Ms. Ligon and I meet.

Q Mr. Bliss, going back to the point in time which we've discussed when there was an intensive case management meeting for E.W., which was April of '95, do you recall that the P&A complaint involved [p. 86] discharge of her to a shelter?

A Yes.

Q You have a recollection of that?

A Yes.

Q I'm just going to ask you whether you have an opinion about whether that would have been an appropriate discharge?

A I would have had concern that she would have returned to the hospital promptly.

\* \* \*

DEPOSITION OF JOSEPH STEED.

\* \* \*

MAY 23, 1996.

\* \* \*

[p. 93] Q Now, do you think it would ever be appropriate to discharge her to a homeless shelter, to discharge E W to a homeless shelter?

A No.

\* \* \*

---



6

FEB 4 1999

CLERK

In The  
**Supreme Court of the United States**  
October Term, 1998

TOMMY OLMSTEAD, Commissioner of the  
Department Of Human Resources of the State of  
Georgia, RONALD C. HOGAN, Superintendent of  
Georgia Regional Hospital/Atlanta, and EARNESTINE  
PITTMAN, Executive Director of the  
Fulton County Regional Board,

*Petitioners,*

v.

L.C. and E.W., each by JONATHAN ZIMRING as  
guardian ad litem and next friend,

*Respondents.*

**On Writ Of Certiorari To The United States  
Court Of Appeals For The Eleventh Circuit**

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80 pp

### QUESTION PRESENTED

Georgia provides for the treatment of its mentally disabled citizens in two main types of residential settings: institutional facilities, and a wide range of settings called "community placements." The State's choice of setting for individuals requiring public care depends on their mental condition, on the fact and extent of their dangerousness and inability to care for themselves, and on fiscal and administrative considerations.

The question presented is:

Whether Title IIA of the Americans with Disabilities Act, 42 U.S.C. § 12132, compels the State to provide treatment for mentally disabled persons in a community placement, when appropriate treatment can also be provided to them in a State hospital.



## PARTIES BELOW

The parties to the proceedings in the court of appeals and in the district court were as listed in the caption, except that pursuant to Rule 25(d) of the Federal Rules of Civil Procedure, Ronald C. Hogan has been automatically substituted for Richard Fields, due to Hogan's succeeding Fields as Superintendent of Georgia Regional Hospital at Atlanta.

## TABLE OF CONTENTS

|   | Page |
|---|------|
| QUESTION PRESENTED.....   | i    |
| PARTIES BELOW.....  | ii   |
| TABLE OF CONTENTS.....  | iii  |
| TABLE OF AUTHORITIES.....   | iv   |
| OPINIONS BELOW.....   | 1    |
| JURISDICTION.....   | 1    |
| STATUTORY AND REGULATORY PROVISIONS....   | 1    |
| STATEMENT OF THE CASE.....  | 2    |
| A. Mental Health Care in the United States.....   | 3    |
| B. Current Mental Health Care in Georgia.....   | 7    |
| C. Facts.....   | 8    |
| D. Proceedings Below.....   | 11   |
| SUMMARY OF THE ARGUMENT.....  | 13   |
| ARGUMENT.....   | 17   |
| I. CUSTOMARY RULES OF STATUTORY INTER-<br>PRETATION UNDERMINE THE ELEVENTH<br>CIRCUIT'S NOVEL CONSTRUCTION OF THE<br>ADA..... | 19   |
| A. THE PLAIN LANGUAGE OF THE ADA<br>DOES NOT SUPPORT THIS THEORY.....   | 19   |
| B. JUDICIAL INTERPRETATIONS OF § 504<br>PRIOR TO THE PASSAGE OF TITLE IIA<br>OF THE ADA DO NOT SUPPORT THIS<br>THEORY.....    | 22   |

## TABLE OF CONTENTS – Continued

## Page

|   |    |
|---|----|
| 1. As Applied to the States, § 504 Assured That Handicapped Individuals Receive Evenhanded Treatment in Relation to Non-Handicapped Individuals .....   | 23 |
| 2. Lower Court Interpretations of § 504 Rejected an Integration Requirement for the States' Mental Institutions .....   | 25 |
| C. EVEN THE ADMINISTRATIVE INTERPRETATIONS UNDER § 504 DID NOT CONSIDER "INTEGRATION" IN THE CONTEXT OF DEINSTITUTIONALIZATION OR LEAST RESTRICTIVE TREATMENT.....                                      | 27 |
| D. TITLE IIA OF THE ADA WAS A LIMITED EXTENSION OF § 504 THAT DID NOT ALTER PRIOR LAW COVERING STATE CARE FOR THE MENTALLY DISABLED..   | 29 |
| E. THE GENERAL LANGUAGE OF TITLE IIA DOES NOT IMPLICITLY REPEAL OR DISPLACE THE VASTLY MORE SPECIFIC AND COMPLEX PROVISIONS OF THE MEDICAID ACT.....  | 30 |
| F. THE TEXT OF THE ADA DOES NOT PROVIDE THE CLEAR STATEMENT NECESSARY FOR CONGRESS TO SEIZE SUCH WIDE-RANGING, UNPREDICTABLE AND LIMITLESS CONTROL OVER A CORE AREA OF STATE AND LOCAL GOVERNMENT ..... | 32 |
| II. THE COURT HAS APPLIED THESE PRINCIPLES BEFORE AND REJECTED A SIMILAR ARGUMENT IN <i>PENNHURST</i> .....   | 33 |

## TABLE OF CONTENTS – Continued

## Page

|  |    |
|--|----|
| III. THE ELEVENTH CIRCUIT'S OPINION RESTS NOT ON THE TEXT OF THE ADA, BUT ON VAGUE STATEMENTS OF CONGRESSIONAL FINDINGS AND PURPOSE AND OF LEGISLATIVE HISTORY, AND ON A REGULATION THAT, AS INTERPRETED, EXCEEDS EXECUTIVE BRANCH POWER ..... | 36 |
| A. THE ELEVENTH CIRCUIT MISREAD THE TEXT OF THE ADA.....   | 36 |
| B. THE LEGISLATURE DID NOT ADDRESS DEINSTITUTIONALIZATION WHEN IT ADOPTED THE ADA.....   | 38 |
| C. THE ELEVENTH CIRCUIT GAVE IMPERMISSIBLE DEFERENCE TO THE ATTORNEY GENERAL'S INTERPRETATION OF THE INTEGRATION REGULATION.....   | 40 |
| 1. The Attorney General's Position Is Not Based on a Permissible Interpretation of the ADA.....  | 40 |
| 2. The Attorney General's Litigation Position Is Not Supported by Its Own Administrative Pronouncements .....  | 41 |
| 3. The Attorney General's Position Raises Serious Constitutional Problems .....  | 43 |
| CONCLUSION .....   | 45 |
| INDEX TO APPENDIX .....  | i  |
| APPENDIX.....  | 1a |



## TABLE OF AUTHORITIES

## Page

## CASES

|   |                        |
|---|------------------------|
| <i>Addington v. Texas</i> , 441 U.S. 418 (1979) .....   | 6, 37                  |
| <i>Alexander v. Choate</i> , 469 U.S. 287 (1985).....   | <i>passim</i>          |
| <i>Atascadero State Hosp. v. Scanlon</i> , 473 U.S. 234 (1985) .....                                | 15, 33                 |
| <i>Bazemore v. Friday</i> , 478 U.S. 385 (1986) .....   | 21                     |
| <i>Benham v. Ledbetter</i> , 785 F.2d 1480 (11th Cir. 1986) ....                                    | 37                     |
| <i>Bob Jones Univ. v. United States</i> , 461 U.S. 574 (1983) ....                                  | 32                     |
| <i>Bowen v. American Hosp. Ass'n</i> , 476 U.S. 610 (1986) .....                                    | 2, 25, 38              |
| <i>Bragdon v. Abbott</i> , 524 U.S. —, 118 S.Ct. 2196 (1998) .....                                  | 22, 23                 |
| <i>Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.</i> , 467 U.S. 837 (1984) .....   | 16, 40, 41, 42, 43, 44 |
| <i>Chisom v. Roemer</i> , 501 U.S. 380 (1991) .....   | 38                     |
| <i>City of Cleburne v. Cleburne Living Center, Inc.</i> , 473 U.S. 432 (1985) .....                 | 17                     |
| <i>Clark v. Cohen</i> , 794 F.2d 79 (3d Cir. 1985), <i>cert. denied</i> , 479 U.S. 962 (1986) ..... | 26                     |
| <i>Crawford Fitting Co. v. J.T. Gibbons, Inc.</i> , 482 U.S. 437 (1987) .....                       | 30                     |
| <i>Doe v. Chiles</i> , 136 F.3d 709 (11th Cir. 1998) .....  | 31                     |
| <i>Garcia v. San Antonio Metropolitan Transit Auth.</i> , 469 U.S. 528 (1985) .....                 | 17, 43                 |
| <i>General Motors Corp. v. Tracy</i> , 519 U.S. 278 (1997) ....                                     | 21                     |

## TABLE OF AUTHORITIES - Continued

## Page

|  |                    |
|--|--------------------|
| <i>Gregory v. Ashcroft</i> , 501 U.S. 452 (1991) ...   | 15, 33, 35, 42, 43 |
| <i>Halderman v. Pennhurst State Sch. &amp; Hosp.</i> , 784 F.Supp. 215 (E.D.Pa.), <i>aff'd</i> , 977 F.2d 568 (3d Cir. 1992) .....   | 26                 |
| <i>Helen L. v. DiDario</i> , 46 F.3d 325 (3d Cir.), <i>cert. denied</i> , 516 U.S. 813 (1995) .....  | 26                 |
| <i>In re Oakes</i> , 8 Law Rep. 123 (Mass. 1845) .....   | 4                  |
| <i>Jackson v. Fort Stanton Hosp. &amp; Training Sch.</i> , 757 F.Supp. 1243 (D.N.M. 1990), <i>rev'd in part on other grounds</i> , 964 F.2d 980 (10th Cir. 1992) .....           | 26, 38             |
| <i>Kilcullen v. New York State Dep't of Transp.</i> , 1999 U.S. Dist. LEXIS 438 (N.D.N.Y. 1999) .....  | 44                 |
| <i>Kimel v. State of Florida Bd. of Regents</i> , 157 F.3d 908 (11th Cir. 1998), <i>cert. granted</i> , No. 98-791, 796 (Jan. 25, 1999), <i>cert. pending</i> , No. 98-829 ..... | 44                 |
| <i>Lorance v. AT&amp;T Technologies, Inc.</i> , 490 U.S. 900 (1989) .....  | 21                 |
| <i>Miller v. Johnson</i> , 515 U.S. 900 (1995) .....   | 40                 |
| <i>Mills v. Rogers</i> , 457 U.S. 291 (1982) .....   | 5                  |
| <i>O'Connor v. Donaldson</i> , 422 U.S. 563 (1975) ....  | 3, 6, 37           |
| <i>P.C. v. McLaughlin</i> , 913 F.2d 1033 (2d Cir. 1990) ....  | 26                 |
| <i>Paralyzed Veterans of America v. D. C. Arena L.P.</i> , 117 F.3d 579 (D.C. Cir. 1997) .....   | 42                 |
| <i>Parham v. J.R.</i> , 442 U.S. 584 (1979) .....  | 6, 37, 38          |

## TABLE OF AUTHORITIES - Continued

Page

|   |               |
|---|---------------|
| <i>Pennhurst State Sch. &amp; Hosp. v. Halderman</i> , 451 U.S. 1 (1981) .....  | passim        |
| <i>Pennsylvania Dep't of Corrections v. Yeskey</i> , 524 U.S. ____ 118 S. Ct. 1952 (1998) .....   | 37            |
| <i>People First of Tennessee v. Arlington Developmental Ctr.</i> , 878 F.Supp. 97 (1992), <i>aff'd</i> at 1998 U.S. App. LEXIS 9537 (unpublished), <i>cert. denied</i> , 142 L.Ed.2d 423 (1998) .....   | 26            |
| <i>Phillips v. Thompson</i> , 715 F.2d 365 (7th Cir. 1983) ....   | 26            |
| <i>Presley v. Etowah County Comm'n</i> , 502 U.S. 491 (1992) .....  | 40            |
| <i>Radzanower v. Touche Ross &amp; Co.</i> , 426 U.S. 148 (1976) .....  | 30            |
| <i>Reno v. Bossier Parish Sch. Bd.</i> , 520 U.S. 471 (1997) ....   | 40            |
| <i>Rice v. Santa Fe Elevator Corp.</i> , 331 U.S. 218 (1947) ..   | 33, 35        |
| <i>S.H. v. Edwards</i> , No. C81-877A (N.D.Ga. 1987) (reprinted at 860 F.2d 1046-1053), <i>aff'd</i> , 860 F.2d 1045 (11th Cir. 1988), <i>reh'g en banc denied</i> , 866 F.2d 1420 (11th Cir. 1989), <i>cert. denied</i> , 491 U.S. 905 (1989), <i>reh'g en banc granted and panel opinion vacated</i> , 880 F.2d 1203 (11th Cir. 1989), <i>aff'd apparently on other grounds</i> , 886 F.2d 292 (11th Cir. 1989) ..... | 26            |
| <i>Southeastern Community College v. Davis</i> , 442 U.S. 397 (1979) .....  | 24            |
| <i>Traynor v. Turnage</i> , 485 U.S. 535 (1988) .....   | 2, 14, 17, 23 |
| <i>United States ex rel. Attorney General v. Delaware &amp; Hudson Co.</i> , 213 U.S. 366 (1909) .....  | 43            |

## TABLE OF AUTHORITIES - Continued

Page

|   |                  |
|---|------------------|
| <i>Will v. Michigan Dep't of State Police</i> , 491 U.S. 58 (1989) .....  | 33               |
| <i>Youngberg v. Romeo</i> , 457 U.S. 307 (1982) .....                     | 2, 6, 18, 38     |
| <i>Zinerman v. Burch</i> , 494 U.S. 113 (1990) .....                      | 18               |
| STATUTES  |                  |
| 20 U.S.C. §§ 1400 <i>et seq.</i> (1994 & Supp. II 1996) ..                | 15, 18           |
| 29 U.S.C. § 794 (1994) .....  | 22               |
| 42 U.S.C. § 12101(a)(3) (1994) .....                                      | 37               |
| 42 U.S.C. § 12132 (1994) .....  | 1, 2, 13, 19, 22 |
| 42 U.S.C. §§ 1396 <i>et seq.</i> (1994 & Supp. II 1996) ..                | 15, 18           |
| 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(A) (1988 & Supp. II 1990) ..... | 31               |
| 42 U.S.C. §§ 1396d(a)(1), -(4)(A), -(15) (1988 & Supp. II 1990) .....     | 31               |
| 42 U.S.C. § 1396d(a)(14), -(16) (1988) .....                              | 31               |
| 42 U.S.C. § 1396d(a)(15) (1988) .....                                     | 31               |
| 42 U.S.C. § 1396n(c)(1) (1988 & Supp. II 1990) .....                      | 31               |
| 42 U.S.C. § 1396n(c)(2)(C) (1988) .....                                   | 32               |
| 42 U.S.C. § 1983 (1994 & Supp. II 1996) .....                             | 11               |
| 42 U.S.C. §§ 6000 <i>et seq.</i> (1994 & Supp. II 1996) .....             | 14               |
| 42 U.S.C. §§ 6000 <i>et seq.</i> (1976 & Supp. III 1979) .....            | 14, 16, 34       |
| 42 U.S.C. §§ 6010(1), -(2) (1976 & Supp. III 1979) .....                  | 14, 16, 34       |



## TABLE OF AUTHORITIES – Continued

Page

|   |            |
|---|------------|
| Community Mental Health Centers Act of 1963,<br>P.L. 88-164, 77 Stat. 290.....  | 5          |
| Developmentally Disabled Assistance and Bill of<br>Rights Act of 1975 .....   | 14, 15, 34 |
| Omnibus Budget Reconciliation Act of 1990, Pub.<br>L. No. 101-508, § 4712, 1990 U.S.C.C.A.N. 104<br>Stat. 1388-187..... | 32         |
| Rehabilitation Act of 1973, 87 Stat. 394, 29 U.S.C.<br>§ 794 (1994).....  | 14         |
| O.C.G.A. § 37-3-20 (1995).....  | 37         |
| O.C.G.A. Chap. 37-2 (1995) .....  | 8          |
| O.C.G.A. Chap. 37-3 (1995 & Supp. 1998) .....   | 7          |
| OTHER AUTHORITIES   |            |
| 135 Cong. Rec. S1972 (daily ed. Feb. 8, 1989).....  | 32         |
| 135 Cong. Rec. S19879 (daily ed. Sept. 7, 1989).....  | 32         |
| 135 Cong. Rec. S8518 (daily ed. May 9, 1989) .....  | 32         |
| 1836 GA. HOUSE J. 21.....   | 4          |
| 1841 Ga. Laws 153.....  | 4          |
| Exec. Order 12250, § 1-202, 45 Fed. Reg. 72995,<br>11-4-80 .....  | 40         |
| H.R. Rep. 101-485(II), 1990 U.S.C.C.A.N. 303 .....  | 29         |
| H.R. Rep. 101-485(III), 101st Cong., 2d Sess. 1990,<br>1990 U.S.C.C.A.N. 445, 10990 WL 121680.....                      | 39         |

## TABLE OF AUTHORITIES – Continued

Page

|  |        |
|--|--------|
| H.R. Rep. No. 101-485(II), 101st Sess. 84 (1990),<br>1990 U.S.C.C.A.N. 267 ..... | 39     |
| S. 384, 101st Cong. § 4 and § 6 (1989) .....                                     | 32     |
| RULES AND REGULATIONS  |        |
| 28 C.F.R. § 35.130(c) (1991).....  | 42     |
| 28 C.F.R. § 35.130(d) (1991) .....   | 28     |
| 28 C.F.R. § 35.130(d) (1998) .....   | 2, 16  |
| 28 C.F.R. Part 35 (1991).....  | 27, 41 |
| 28 C.F.R. Part 35, Supp. Info. (56 Fed. Reg. 35694,<br>7-26-91) .....            | 40     |
| 28 C.F.R. Part 41, 43 Fed. Reg. 40686, 8-11-81 .....                             | 27     |
| 42 C.F.R. § 441.302(d)(1)-(2) (1996) .....                                       | 31     |
| 45 C.F.R. Part 85, 43 Fed. Reg. 2132, 1-13-78 .....                              | 27     |
| 45 C.F.R. § 85.51(c) (1978).....   | 28     |
| 45 C.F.R. § 85.51(d).....  | 28     |
| 45 C.F.R. § 85.51(d) (1978) ( <i>see</i> App. A, 4a).....                        | 28     |
| Rule 25(d) of the Federal Rules of Civil Procedure .....                         | ii     |
| 43 Fed. Reg. 2132, 1-13-78 .....   | 28     |

## TABLE OF AUTHORITIES - Continued

Page

## MISCELLANEOUS

|   |      |
|---|------|
| CHARLES E. GOSHEN, DOCUMENTARY HISTORY OF PSYCHIATRY (1967) .....   | 3    |
| E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL (1988) ....  | 6, 8 |
| E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL HEALTH CRISIS (1997).....  | 7, 8 |
| FRANK T. LINDMAN & DONALD M. MCINTYRE, JR., THE MENTALLY DISABLED AND THE LAW (1st ed. 1961) .....  | 4    |
| GERALD N. GROB, FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA (1991) .....   | 5    |
| GERALD N. GROB, MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875 (1973).....   | 3    |
| MURRAY LEVINE, THE HISTORY AND POLITICS OF COMMUNITY MENTAL HEALTH (1981) .....   | 5    |
| PAUL S. APPELBAUM, ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE (1994).....  | 4, 5 |
| SAMUEL JAN BRAKEL, JOHN PARRY & BARBARA A. WEINER, THE MENTALLY DISABLED AND THE LAW (3d ed. 1985) .....  | 4, 5 |
| Samuel W. Hamilton, <i>The History of American Mental Hospitals, in ONE HUNDRED YEARS OF AMERICAN PSYCHIATRY</i> (J.K. Hall, Gregory Zilboorg, & Henry Alden Bunker eds., 1944) ..... | 3, 4 |
| The Americans With Disabilities Act, Title II Technical Assistance Manual, Covering State and Local Government Programs and Services, 1993 edition .....                              | 42   |

## OPINIONS BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit is reported at 138 F.3d 893 (1998), and is included in the appendix to the State's petition for a writ of certiorari ("Pet."). See Pet. 1a-30a. The order on the merits by the United States District Court for the Northern District of Georgia, No. 1:95-CV-1210-MHS, 1997 WL 148674 (Mar. 26, 1997) is unreported. See Pet. 31a-42a.

## JURISDICTION

The court of appeals entered its opinion and judgment on April 8, 1998 (Pet. 1a) and entered its denial of Petitioners' Motion for Rehearing and Suggestion of Rehearing En Banc on July 1, 1998 (Pet. 43a). The petition for a writ of certiorari was filed on September 29, 1998, and this Court granted the petition on December 14, 1998.

## STATUTORY AND REGULATORY PROVISIONS

42 U.S.C. § 12132 (1994) (the Americans With Disabilities Act of 1990):

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.



28 C.F.R. § 35.130(d) (1998):

A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

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### STATEMENT OF THE CASE

This case represents an attempt by a federal agency with no historic expertise in the area of mental health care to resolve a complex social and medical debate through the general terms of the Americans with Disabilities Act (the ADA). 42 U.S.C. § 12132 (1994). This is not the first national effort to impose a one-size-fits-all solution to an intricate medical problem – here, institutionalization versus deinstitutionalization of mental health care – through an expansive interpretation of federal law. See, e.g., *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981); *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Alexander v. Choate*, 469 U.S. 287 (1985); *Bowen v. American Hosp. Ass'n*, 476 U.S. 610 (1986); *Traynor v. Turnage*, 485 U.S. 535 (1988). Nor is it the first time that litigants have argued that a federal statute compels the States to provide care for the mentally disabled in the “least restrictive” environment. See *Pennhurst*.

While this Court has rejected these interpretations in the past, the Eleventh Circuit in this action accepted the contention that the ADA imposes an affirmative obligation on the States to provide psychiatric care in the “least restrictive” setting, which generally will require community rather than hospital care. Before demonstrating why

that conclusion is wrong, it is appropriate to discuss briefly the history of mental health care in this country. This history sets the stage for today’s dispute and establishes a context for resolving it.

### A. Mental Health Care in the United States

Viewed over the long sweep of history, hospitals for the care and treatment of mentally disabled persons are recent innovations. During the American colonial period, the care of mentally disabled persons was entrusted to their families or, failing that, to jails, poorhouses, or boarding arrangements financed by local communities. GERALD N. GROB, *MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875* 4-12 (1973).

The need for separate facilities to care for the mentally disabled arose from the sheer growth of the colonies’ population and from the inhumane treatment inflicted on the disabled in community settings. See *O’Connor v. Donaldson*, 422 U.S. 563, 582 (1975) (Burger, C.J., concurring); GROB, *supra*, at 13; Dorothea Lynde Dix, *Appeal on Behalf of the Insane of Massachusetts*, in CHARLES E. GOSHEN, *DOCUMENTARY HISTORY OF PSYCHIATRY* 502-04 (1967). While the first two hospitals that cared for the mentally ill were founded before the Revolutionary War, there were still only six such facilities by 1830. Samuel W. Hamilton, *The History of American Mental Hospitals*, in *ONE HUNDRED YEARS OF AMERICAN PSYCHIATRY* 73-78, 153 (J.K. Hall, Gregory Zilboorg, & Henry Alden Bunker eds., 1944).

From 1830 onward, public pressure, poor community care conditions, as well as new pressure from vocal

reformers such as Dorothea Dix, prompted State after State to open at least one mental hospital. As a result of this development, more than 75 public facilities existed by 1880. Hamilton, *supra*, at 153-56; Dix, *supra*.

Following this national trend, Georgia opened its first State mental hospital in 1842. In doing so, the Georgia governor told the legislature that "[h]umanity requires that a comfortable place of refuge should be provided for the [mentally ill], to alleviate their sufferings, and to protect the community against their involuntary acts; and that such as are indigent should be maintained at the public expense." 1836 GA. HOUSE J. 21; see 1841 Ga. Laws 153. The governor's dual rationale for civil commitment – the *parens patriae* interest in providing care and treatment for the disabled, and the police power concern for the public safety – typified early State rationales for commitment, which persisted until at least the early 1960s. See, e.g., *In re Oakes*, 8 Law Rep. 123, 125 (Mass. 1845); FRANK T. LINDMAN & DONALD M. MCINTYRE, JR., *THE MENTALLY DISABLED AND THE LAW* 17-18 (1st ed. 1961).

Throughout this period, the States periodically changed their procedural requirements for involuntary civil commitment, sometimes tightening them and at other times relaxing them. PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 20 (1994); SAMUEL JAN BRAKEL, JOHN PARRY & BARBARA A. WEINER, *THE MENTALLY DISABLED AND THE LAW* 15 (3d ed. 1985). But there was no widespread sentiment for closing hospitals or deinstitutionalizing care during this period. The main concern lay in finding ways to improve

the hospitals. GERALD N. GROB, *FROM ASYLUM TO COMMUNITY: MENTAL HEALTH POLICY IN MODERN AMERICA* 3 (1991).

Seeds of change were planted soon after World War II. A number of sociologists formulated theories that ultimately led to the conclusion that either mental illness did not exist and thus no hospital treatment was necessary for it, or if it did exist, then it could be treated in "community" facilities. APPELBAUM, *supra*, at 4-9; GROB (1991), *supra*, at 283-88. Also, the advent of effective antipsychotic medications in the early 1950s held out the promise of successful community treatment for many. See *Mills v. Rogers*, 457 U.S. 291, 293 n.1 (1982).

By the early 1960s, the new sociological theories had gained currency with small but influential groups within the psychiatric and legal communities. Partly as a result of that change, the Community Mental Health Centers Act of 1963, P.L. 88-164, 77 Stat. 290, was enacted. The law funded the construction of such centers in all participating States and eventually funded staffing grants for distribution by the National Institute of Mental Health directly to local sponsors of community mental health centers, rather than through State mental health authorities. MURRAY LEVINE, *THE HISTORY AND POLITICS OF COMMUNITY MENTAL HEALTH*, 53-55 (1981).

The next 20 years saw remarkable ferment in mental health law. By its end, many States had rewritten their statutes to provide a wide range of protections for the disabled – a very narrow basis for civil commitment, a full panoply of procedural safeguards for commitment, a right to treatment, a right to refuse treatment, and a right to be treated in the "least restrictive" setting. See BRAKEL,



PARRY & WEINER, *supra*, at 21-33. While this Court addressed some of these issues under federal law, it consistently found that the Constitution does not guarantee unqualified individual rights in this area. See, e.g., *O'Connor v. Donaldson*, 422 U.S. 563 (1975) (mental illness without dangerousness cannot serve as a basis for purely custodial care); *Addington v. Texas*, 441 U.S. 418 (1979) (beyond-a-reasonable-doubt standard of proof not required for commitment hearing); *Parham v. J.R.*, 442 U.S. 584 (1979) (judicial proceeding not required for admission of minors to mental hospitals); *Youngberg v. Romeo*, 457 U.S. 307 (1982) (right to habilitation limited to minimally adequate or reasonable training to ensure safety and freedom from undue restraint).

By the mid-1980s, these changes in mental-health law, together with the availability of antipsychotic medication, led to large transfers of patients from State mental hospitals into communities across the country. Government figures show that

[t]he census of state mental hospitals was reduced by 197,921 individuals during the 1960s, and this reduction continued during the 1970s by another 205,455 persons. . . . Altogether between 1955 and 1984 a total of 433,407 beds in state mental hospitals were taken out of use, or 80 percent of the 552,150 beds occupied in 1955.

E. FULLER TORREY, *NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL*, 139, 219 (1988) (using data from National Institute of Mental Health). A comparison between 1955 and 1994 shows that the nation had an

actual mental health hospitalization decrease of 82 percent and an effective decrease (considering national population change) of 91.3 percent. E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL HEALTH CRISIS*, 205-07 (1997).

## B. Current Mental Health Care in Georgia

Georgia's delivery of mental health services has been affected by these national trends. In 1978, the General Assembly overhauled its Mental Health, Mental Retardation, and Substance Abuse Codes. As a result, Georgia law now permits involuntary hospitalization only after an extensive hearing and only upon the satisfaction of stringent standards of dangerousness or inability to care for one's self. There is a right to the least restrictive alternative placement, within the limits of state funds specifically appropriated for such care; a right to treatment; a right to refuse treatment; a right to petition the court for release or for protection of institutional rights; and a right to release at any time that the chief medical officer determines that the patient no longer requires treatment. O.C.G.A. Chap. 37-3 (1995 & Supp. 1998). The Code also provides for voluntary hospital treatment when a mentally ill person is suitable for treatment, as well as for voluntary and involuntary outpatient treatment as a means of avoiding inpatient care. *Id.* In 1993, the General Assembly restructured the entire system for delivering mental health care by transferring most of the control over treatment and funding from the statewide mental health agency, which operates the State's mental

hospitals, to regional and community boards, which operate or contract for community services. O.C.G.A. Chap. 37-2 (1995).

Georgia's experience with deinstitutionalization of mental health care parallels the national experience. Between 1955 and 1984, Georgia had a 66 percent decrease in the number of hospitalized mental patients. TORREY (1988), *supra*, at 219. And between 1955 and 1994, Georgia had an actual hospitalization decrease of 72.3 percent and an effective decrease (with population growth) of 85.7 percent. TORREY (1997), *supra*, at 207.

### C. Facts

When the present case began, both L.C. and E.W. were patients in the 60-bed Treatment Unit of Georgia Regional Hospital-Atlanta (GRH-A), one of seven regional hospitals currently operated by the State. Joint Appendix (J.A.) 2, 13, 61, 66.

Their histories and their conditions then were similar in most relevant aspects. Both of them had been admitted to GRH-A many times over the years due to difficulties associated with their illnesses, including on some occasions aggressive acts toward others. J.A. 14, 63, 97, 99, 106, 107. Both of them were mentally ill as well as mentally retarded. L.C. was diagnosed as having schizophrenia, undifferentiated type, chronic, and mild retardation (J.A. 105), while E.W. was found to have a borderline personality disorder and mild retardation. J.A. 107-08.

L.C. was admitted in May 1991 after exhibiting aggressive and psychotic behavior toward a staff member at the residential community placement where she had lived for approximately a year. J.A. 14. E.W. was admitted involuntarily in December 1994 when she appeared to be hallucinating, paranoid, and too "loose" to care for herself. J.A. 107.

At GRH-A, treatment was provided to both plaintiffs by Dr. Dilipkumar Patel (a Board-certified psychiatrist) and a multidisciplinary treatment team, following an individualized service plan outlining the goals and methods of treatment. J.A. 15, 105, 108. In early 1993, GRH-A staff members began to work on obtaining a community placement for L.C. J.A. 15.

In February 1994, L.C.'s social worker noted that community placement was difficult, because significant funding would be needed to maintain her in the community. R59 (Plaintiffs' Statement of Material Facts), ¶157 (references to the district court record docket entries are denoted as (R#)).

L.C. began to attend a community day program in August of that year. J.A. 19. The treatment team arranged for L.C. to live with her mother on a trial basis, beginning in May 1995. J.A. 106. Problems arose during the trial visit, and the parties in the present suit entered into a consent order for L.C. to be evaluated and treated at a State residential retardation center. J.A. 75. After several months there, L.C. was placed, with public funds, in a residential community placement with additional support services, and she has remained there since. *See* Pet. 2a n.2.



E.W.'s course of treatment was more problematic, due to the variability of her illness, her behaviors, and her medical condition. On three occasions she stabilized, and the treatment team arranged trial visits to community placements as a transition to discharge. J.A. 108. On each occasion she was returned to GRH-A due to aggressive conduct or threats toward herself or others, among other reasons. *Id.*

In March 1995, Dr. Patel consulted about E.W.'s treatment with four persons with extensive experience in treating persons with mental retardation. R.A. 109-12. They all concluded that E.W. was a very challenging patient and agreed with Dr. Patel that her personality disorder, not the mental retardation component of her diagnosis, appeared to be the area requiring focused treatment. *Id.*

E.W.'s mental condition and her behavior improved slowly and she became more compliant with treatment. *Id.* In March 1996, however, mental retardation specialists with the Fulton County Regional Board (which is responsible for making E.W.'s placement assessments) concluded that E.W. should not be placed in the community at that time. J.A. 117. While the motions for summary judgment were pending, the Fulton County Regional Board did not have any uncommitted Medicaid waiver funding or State funds available to provide community residential mental retardation services to E.W. J.A. 116. These funds were being used to provide services for other disabled persons. *Id.* The director of State mental health services noted subsequently that the State had no such funds available either. J.A. 135-38. He affirmed that the State "cannot comply with its duty to provide adequate

facility [i.e., institution] programs if it moves any more of its facility funds to community programs." J.A. 137.

In November 1996, E.W. was transferred to the Medical Surgical Center of Central State Hospital in Milledgeville, Georgia, for monitoring and treatment of serious kidney problems. *See* J.A. 142, 155. While a patient there, she underwent surgery at an Atlanta hospital and then returned to Central State to receive aftercare and psychiatric treatment. *Id.* She was then transferred to a skilled-nursing-care unit at Central State, where she remained at the time of the district court's judgment in this case. By the time of the decision by the court of appeals, E.W. had also been discharged to a community placement due to her improved physical and mental condition and to additional funds becoming available. Pet. 2a n.2.

#### D. Proceedings Below

In filing this lawsuit, plaintiffs sought a declaration that their continued stay at GRH-A violated the Fourteenth Amendment and the ADA, and did so under 42 U.S.C. § 1983 (1994 & Supp. II 1996). J.A. 4, 62-63. They also demanded an injunction providing publicly financed community placements and services for themselves immediately. They did not seek damages of any type. *Id.* They claimed that they no longer required *inpatient care*, while conceding that they remained mentally disabled and in need of substantial care of some type, and that the continuation of their hospitalization established that they were not receiving minimally adequate care. J.A. 2-4, 61-63.

On cross-motions for summary judgment, the district court granted the plaintiffs' motion on the ADA claim and ordered the State to provide treatment in a less restrictive setting and to place them immediately in "appropriate" residential community settings with all "appropriate" services. Pet. 39a; *see* R91-2 n.1 (order denying stay). In the district court's view, "under the ADA, unnecessary institutional segregation of the disabled constitutes discrimination *per se*, which cannot be justified by a lack of funding." Pet. 37a. The district court did not rule on the constitutional claim. Pet. 40a.

The court of appeals affirmed. "By definition," it concluded, "where, as here, the State confines an individual with a disability in an institutionalized setting when a community placement is appropriate, the State has violated the core principle underlying the ADA's integration mandate." Pet. 8a.

The court then declared that under the ADA lack of funds was not a defense except "in the most limited of circumstances." Pet. 20a. It held that "[u]nless the State can prove that requiring it to make these additional expenditures [for the plaintiffs' two community placements] would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides, the ADA requires the State to make these additional expenditures." Pet. 29a. The court of appeals remanded the case for consideration of this issue.

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## SUMMARY OF ARGUMENT

1. Title IIA of the Americans with Disabilities Act does not impose a "least restrictive treatment" requirement on the States when they provide psychiatric care to their citizens. By its terms, the statute protects only "qualified individual[s] with a disability" from (1) being "excluded from participation in or be[ing] denied the benefits of the services, programs, or activities of a public entity" because of their disability, or (2) being "subjected to discrimination" because of their disability. 42 U.S.C. § 12132 (1994). Neither theory of liability covers the complex medical, social and fiscal policies that go into a State's decision to provide or deny a community-care program. And neither theory makes a national value judgment that the "least restrictive treatment" must be provided to psychiatric patients, to say nothing of imposing on the States the massive and indeterminate fiscal burdens that would follow such a decision. Every pertinent rule of statutory interpretation undermines the Eleventh Circuit's conclusion to the contrary.

a. At least two textual flaws plague a "least restrictive treatment" construction of the ADA. As to the first theory of liability, plaintiffs were not denied a benefit – here, a community placement – by reason of their disability. At the few times that "all the experts agreed" (if, indeed, they ever did) that plaintiffs could be appropriately treated in the community, there was no funding to do so, and plaintiffs had to wait for a community placement for that reason, not because of their disability. As to the second theory of liability, discrimination generally requires a showing of uneven treatment as between similarly situated individuals. In this case, no class of



similarly situated individuals was even identified, let alone shown to be given preferential treatment.

b. Prior judicial constructions of the language of Title IIA of the ADA, as enacted in 1990, confirm this interpretation. Title IIA mirrors in all pertinent respects the language of § 504 of the Rehabilitation Act of 1973, 87 Stat. 394, 29 U.S.C. § 794 (1994), which has never affirmatively imposed a "least restrictive treatment" mandate on the States' treatment of the disabled. The provision addresses primarily "evenhanded treatment" between the handicapped and non-handicapped, not evenhanded treatment between different categories of handicapped individuals. *Traynor v. Turnage*, 485 U.S. 535, 548 (1988); see *Alexander v. Choate*, 469 U.S. 287, 304 (1985). "There is nothing in the Rehabilitation Act," the Court has confirmed, requiring "that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." *Traynor*, 485 U.S. at 549. Prior to the passage of the ADA in 1990 (and indeed, prior even to 1995), the lower courts all followed this unwavering view as well.

c. It is inappropriate to credit Congress with imposing a "least restrictive treatment" requirement on the States through the ADA for another reason as well. Congress has shown its ability to enact related mandates through specific language, and yet it did not use that language here. In the Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. §§ 6000 *et seq.* (1976 & Supp. III 1979) (now the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000 *et seq.* (1994 & Supp. II 1996)), Congress specifically used "least restrictive treatment" language, albeit

in a preferential, not mandatory, setting. Elsewhere, in the Individuals with Disability Education Act, 20 U.S.C. §§ 1400 *et seq.* (1994 & Supp. II 1996), Congress has imposed a similar "appropriate" education requirement. Likewise, the Medicaid laws, 42 U.S.C. §§ 1396 *et seq.* (1994 & Supp. II 1996), regulate in excruciating detail the States' provision of psychiatric care and yet they provide only limited funding for community treatment. There is no indication that the general terms of the ADA were designed to displace the specific requirements of this extensive regulatory scheme.

d. Nor do the general terms of the ADA overcome the "unmistakably clear" hurdle that the Court has established for litigants who seek an interpretation of a statute that will "alter the 'usual constitutional balance between the States and the Federal Government,' " *Gregory v. Ashcroft*, 501 U.S. 452, 460 (1991) (quoting *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (1985)), or that will impose an "enormous financial burden" and "massive obligation" on the States, *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 24 (1981). Surely a sudden decision to require all States to provide the "least restrictive treatment" to their citizens in State hospitals would brush up against the boundaries of section five power under the Fourteenth Amendment, if not surpass them, while at the same time imposing substantial and largely indeterminate new financial obligations on the States.

2. *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), rejected a similar effort to alter the States' provision of mental disability care to their citizens under the Developmentally Disabled Assistance and Bill of Rights Act of 1975. There, too, several institutionalized

patients claimed a right to receive care in "community living arrangements." 451 U.S. at 6. And there, too, they claimed that federal law gave them this right because it imposed a "least restrictive" treatment requirement on the States' provision of mental disability care. *Id.* at 7, 10. Even though the *Pennhurst* statute said that patients had "a right to appropriate treatment," and that this treatment "should be provided in the setting that is least restrictive of the person's personal liberty," 42 U.S.C. § 6010(1), -(2) (1976 & Supp. III 1979), the Court rejected the argument. It found insufficient evidence of an "unmistakably clear" intent on Congress's part to impose any such obligation on the States. Instead, it concluded that the law merely established a congressional preference, not requirement, that States provide care in this manner. 451 U.S. at 15-27. The same conclusion applies with equal if not greater force here since the ADA does not even use the explicit "least restrictive" treatment language found not to suffice in *Pennhurst*.

3. Nor can plaintiffs sidestep this conclusion by relying on an executive-branch regulation promulgated by the Department of Justice. The administrative regulation says that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (1998). No cognizable principle of administrative deference, however, permits enforcement of this regulation in a way that requires States suddenly to provide mental health care in the "least restrictive" environment. See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). Prior interpretations of the language that became the

ADA (as well as prior interpretations of this same regulation under § 504 of the Rehabilitation Act) made clear that it *did not* generally cover requests for evenhanded treatment in benefits as among different categories of handicapped individuals. *Traynor, supra*. But even if there were doubt on this score, no relevant precedent allows Congress to alter profound State-Federal allocations of responsibility under the radar of the clear-statement rule, but instead silently to delegate to executive-branch agencies the fundamental decision whether, when and how to alter the constitutional balance between the States and the Federal Government. Such an approach would prevent Congress from being held accountable for these decisions and would limit the States' ability to influence them. Cf. *Garcia v. San Antonio Metropolitan Transit Auth.*, 469 U.S. 528 (1985).

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## ARGUMENT

In concluding that the State of Georgia violated federal law through its treatment of mentally disabled patients in State hospitals, the Eleventh Circuit did not rely on any of a number of traditional theories that bar improper treatment of the disabled. No one has alleged that any improper motive lay behind Georgia's laws. See *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432 (1985). There thus is no allegation, let alone a finding, that the State's system of caring for mentally disabled individuals in hospitals has been motivated in any way by discriminatory animus toward the disabled. Nor is this a disparate-impact case. Cf. *Alexander v. Choate*, 469 U.S. 287 (1985) (limiting the availability of this theory under



§ 504 of the Rehabilitation Act). Plaintiffs thus have not shown – as indeed they could not show – that Georgia's efforts to provide care for the mentally disabled have had a disparate impact upon them. A program designed solely to benefit the disabled necessarily will solely impact the disabled, but it does not by that reason create a cognizable claim of discrimination. Plaintiffs are not here because they were ignored, but because the State proceeded to provide care for them.

As to the institutional care itself, moreover, plaintiffs do not allege that their initial involuntary confinement violated any constitutional requirements. See *Zinerman v. Burch*, 494 U.S. 113 (1990). Nor has there been any finding that the treatment actually provided at the institution fell below constitutional standards. See *Youngberg v. Romeo*, 457 U.S. 307 (1982).

Similarly, this is not a case about lack of reasonable accommodation in the employment setting. Plaintiffs are not seeking, and have not sought, employment that the State has denied them or failed to accommodate. Nor is this a case about the denial of a free appropriate education for disabled individuals. 20 U.S.C. §§ 1400 *et seq.* (1994 & Supp. II 1996). Lastly, this is not a case about failure to comply with the intricate, detailed requirements of the Medicaid laws, 42 U.S.C. §§ 1396 *et seq.* (1994 & Supp. II 1996), including extensive provisions regarding care for the disabled. Neither the federal government in general nor the Health Care Financing Administration ("HCFA") in particular has registered any complaint about Georgia's care for the disabled in this case.

Instead, the Eleventh Circuit concluded that the general terms of the Americans with Disabilities Act require Georgia, and presumably all other States as well, affirmatively to provide the least restrictive care for hospitalized mental-health patients and therefore to place them in the community whenever such treatment would be "appropriate." But this novel theory has no statutory or precedential pedigree. Neither the specific terms of the ADA, the general policy underlying the law nor the history of legislation behind it require wholesale outplacement of mental-health patients. And the Medicaid laws, which specifically regulate this area, positively permit what Georgia has done. In the final analysis, the important nationwide debate about the merits of institutionalization versus deinstitutionalization simply was not decided suddenly and quietly through the general terms of the ADA.

# **I. CUSTOMARY RULES OF STATUTORY INTERPRETATION UNDERMINE THE ELEVENTH CIRCUIT'S NOVEL CONSTRUCTION OF THE ADA.**

## **A. THE PLAIN LANGUAGE OF THE ADA DOES NOT SUPPORT THIS THEORY.**

The language of the ADA does not support the Eleventh Circuit's analysis. In plain terms, Title IIA provides:

Subject to the provisions of this subchapter, no qualified individual with a disability shall, *by reason of such disability*, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132 (1994) (emphasis added).

This provision sets forth two liability benchmarks with respect to a State's treatment of "qualified individuals" with a disability. A State may not (1) deny such individuals a benefit, program, or activity by reason of the disability, or (2) discriminate against such individuals on the basis of their disability. Neither theory of liability applies here.

Plaintiffs were not denied any benefits or services because of their disabilities. Georgia's denial of care in these cases and in the general run of cases occurs in spite of a person's disability, not because of it. In Georgia, as in most States, community placements may be denied due to insufficient space in the program, insufficient federal or state resources, or safety concerns. That is not to say the ADA could never apply here. If the State denied a community placement to a mentally disabled individual because she was blind, for example, that could amount to the denial of a benefit based on a disability. Yet there has been no showing that the State has denied these services because of anyone's disability. Nor could there be on this record.

To the extent the Eleventh Circuit meant to conclude that community care may not be denied due to the seriousness of a mental disability, that analysis overlooks the requirement that an individual must be "qualified" for the benefit. It also leads to results that are administratively awkward and positively at odds with the beneficial goals of the ADA. This interpretation would lead to a regime in which the more serious the psychiatric condition, the more sound the basis for a claim under the ADA. That approach of course gets an exceedingly complex medical and police-power judgment – whether to release

an individual into the community – exactly backwards. The States ought to have more flexibility, not less, when it comes to institutionalizing patients who have the most serious of disabilities. The Eleventh Circuit's construction has another perverse consequence as well. It penalizes States for offering community, home, or intermediate care in the first instance because it provides one more option of "least restrictive treatment" to demand, and for like reasons it will forever discourage States from setting up psychiatric-care programs with limited enrollment because they will potentially violate the ADA by not offering the benefit to everyone at the outset. Congress deserves more credit than to have compelled either counterproductive result.

Nor can Plaintiffs show that the State *discriminated* against them because of their disability. Again, there was no such finding. In the ordinary sense of the word, "discrimination" necessarily requires uneven treatment of similarly situated individuals. *General Motors Corp. v. Tracy*, 519 U.S. 278 (1997); *Lorance v. AT&T Technologies, Inc.*, 490 U.S. 900, 905 (1989); *Bazemore v. Friday*, 478 U.S. 385, 395 (1986) (Brennan, J., concurring). In this case, no class of similarly situated individuals was even identified, let alone shown to be given preferential treatment. In the end, nothing about the text of the ADA imposes an affirmative "integration" or "least restrictive environment" requirement on the States.



**B. JUDICIAL INTERPRETATIONS OF § 504 PRIOR TO THE PASSAGE OF TITLE IIA OF THE ADA DO NOT SUPPORT THIS THEORY.**

Context and history confirm this reading of the statute. Section 504 of the Rehabilitation Act of 1973 never imposed an integration mandate on the States, predates the passage of Title IIA of the ADA in 1990, and uses language that, in all respects pertinent to this dispute, is identical to it:

*§ 504 of the Rehabilitation Act:* No otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . . 29 U.S.C. § 794 (1994).

*§ 12132 of the ADA:* Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. 42 U.S.C. § 12132 (1994).

Because the two provisions are identical in nature, judicial constructions of the former (§ 504) inform judicial constructions of the latter (ADA). "When administrative and judicial interpretations have settled the meaning of a statutory provision, repetition of the same language in a new statute indicates, as a general matter, the intent to incorporate its administrative and judicial interpretations as well." *Bragdon v. Abbott*, 524 U.S. \_\_\_, 118 S.Ct. 2196,

2208 (1998). As *Bragdon* makes clear, settled interpretations of the Rehabilitation Act inform construction of parallel sections of the ADA.

**1. As Applied to the States, § 504 Assured That Handicapped Individuals Receive Evenhanded Treatment in Relation to Non-Handicapped Individuals.**

In construing § 504 prior to 1990, the Court uniformly recognized that its central purpose was to assure that handicapped individuals receive "evenhanded treatment" with respect to those who are not handicapped. *Traynor v. Turnage*, 485 U.S. 535, 548 (1988); *Alexander v. Choate*, 469 U.S. 287, 304 (1985) ("Section 504 seeks to assure evenhanded treatment and the opportunity for handicapped individuals to participate in and benefit from programs receiving federal assistance."); *id.* at 303 (Section 504 does "not guarantee that each recipient will receive that level of health care precisely tailored to his or her needs."). Notably, application of § 504 to allegations of discrimination among benefits provided to classes of handicapped persons was specifically limited. "There is nothing in the Rehabilitation Act," the Court confirmed, "that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." *Traynor*, 485 U.S. at 549 (upholding a Veterans' Administration regulation that excluded "primary alcoholics" from a benefit that was extended to persons disabled by alcoholism related to a mental disorder). This reading of § 504 thus allows the States to provide special services to developmentally disabled individuals, for example, without being required

to provide those same services to all individuals suffering from schizophrenia. Otherwise, § 504 would penalize the entity for providing the benefit and would potentially discourage the provision of disability benefits in the first instance.

Case law also rejected attempts to create broad affirmative obligations under § 504. In *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979), for example, the Court concluded that "neither the language, purpose, nor history of § 504 reveals an intent to impose an affirmative-action obligation on all recipients of federal funds." Even when affirmative obligations were created, it was only because § 504 "require[d] that an otherwise qualified handicapped individual must be provided with meaningful access to the benefit that the grantee offers." *Alexander v. Choate*, *supra*, at 469 U.S. at 301 (emphasis added). The justification of access to State benefits is not present here.

The Court further concluded that § 504 did not encroach on the States' decisions about the types of disability services they provided under the Medicaid Act. In *Alexander v. Choate*, the Court considered whether Tennessee's proposed reduction in Medicaid coverage (a reduction in the number of annual days of inpatient hospital care) violated § 504 due to its disparate impact on the disabled. The Court held that it did not, stating:

In enacting the Rehabilitation Act and in subsequent amendments, Congress did focus on several substantive areas – employment, education, and the elimination of physical barriers to access – in which it considered the societal and personal costs of refusals to provide meaningful

access to the handicapped to be particularly high. But nothing in the pre- or post-1973 legislative discussion of § 504 suggests that Congress desired to make major inroads on the States' long-standing discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid. . . .

469 U.S. at 306-07 (citations and footnotes omitted) (emphasis added).

Nor, for similar reasons, were the anti-discrimination requirements of § 504 concerned with "adequate and appropriate psychiatric care or safe and humane living conditions for persons institutionalized because of handicap. . . ." *Bowen v. American Hosp. Ass'n*, 476 U.S. 610, 640-41 (1986) (plurality opinion). The provision was never intended to allow intervention by federal agencies into treatment decisions traditionally left by State law to parents, physicians, and state agencies. *Id.* at 645. See *id.* at 672 ("nothing in § 504 authorizes [the secretary] to commandeer state agencies . . . [these] agencies are not field offices of the HHS bureaucracy and they cannot be conscripted against their will as foot soldiers in a federal crusade.") In short, § 504 had long been construed to be an anti-discrimination statute, not a national health care statute.

## 2. Lower Court Interpretations of § 504 Rejected an Integration Requirement for the States' Mental Institutions.

Prior to the 1990 passage of Title IIA of the ADA, many lower courts were invited to adopt an affirmative integration or "least restrictive treatment" requirement



under § 504. None did. They specifically found that nothing in § 504 required the States to provide mental disability treatment in a community placement simply because it was possible, appropriate, or even better than institutional treatment. Circuit courts: *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. 1990); *Clark v. Cohen*, 794 F.2d 79 (3d Cir.), cert. denied, 479 U.S. 962 (1986) (later limited in *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir.), cert. denied, 516 U.S. 813 (1995)); *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983). District courts: *People First of Tennessee v. Arlington Developmental Ctr.*, 878 F.Supp. 97 (1992), aff'd at 1998 U.S. App. LEXIS 9537 (unpublished), cert. denied, 142 L.Ed.2d 423 (1998); *Jackson v. Fort Stanton Hosp. & Training Sch.*, 757 F.Supp. 1243 (D.N.M. 1990), rev'd in part on other grounds, 964 F.2d 980 (10th Cir. 1992); *S.H. v. Edwards*, No. C81-877A (N.D.Ga. 1987) (reprinted at 860 F.2d 1046-1053), aff'd, 860 F.2d 1045 (11th Cir. 1988), reh'g en banc denied, 866 F.2d 1420 (11th Cir. 1989), cert. denied, 491 U.S. 905 (1989), reh'g en banc granted and panel opinion vacated, 880 F.2d 1203 (11th Cir. 1989), aff'd apparently on other grounds, 886 F.2d 292 (11th Cir. 1989) (distinguished by panel in present case, Pet. 19a).

It was not until 1995 that the first court of appeals followed an "integration mandate" approach to disability services. *Helen L. v. Didario*, 46 F.3d 325 (3d Cir. 1995). Cf. *Halderman v. Pennhurst State Sch. & Hosp.*, 784 F.Supp. 215, 224 (E.D.Pa.), aff'd, 977 F.2d 568 (3d Cir. 1992).

**C. EVEN THE ADMINISTRATIVE INTERPRETATIONS UNDER § 504 DID NOT CONSIDER "INTEGRATION" IN THE CONTEXT OF DEINSTITUTIONALIZATION OR LEAST RESTRICTIVE TREATMENT.**

Nor can plaintiffs show that the administrative regulations under § 504 required deinstitutionalization or "least restrictive treatment" prior to 1990. Three key events inform the regulatory history at issue here. First, in 1978, the Department of Health, Education and Welfare ("HEW") issued regulations and interpretive materials to coordinate federal agency enforcement of § 504. 45 C.F.R. Part 85, 43 Fed. Reg. 2132, 1-13-78 (see App. A, 1a). Second, in 1980, the coordination function was transferred to the Department of Justice ("DOJ"), and the next year DOJ redesignated HEW's coordination regulations, without change, as its own. 28 C.F.R. Part 41, 43 Fed. Reg. 40686, 8-11-81 (see App. B, 6a). Third, a year after the ADA was adopted (see App. C, 7a, for Title IIA), DOJ issued its own coordination regulations. 28 C.F.R. Part 35 (1991) (see App. D, 10a).

The § 504 regulations issued by HEW primarily addressed treatment of the handicapped relative to the non-handicapped. One, however, specifically addressed federally funded disability services, and affirmatively permitted the States to provide benefits to members of one class of handicapped individuals but not to another:

The exclusion of nonhandicapped persons from the benefits of a program limited by federal statute or executive order to handicapped persons or the exclusion of a specific class of handicapped persons from a program limited by

federal statute or executive order to a different class of handicapped persons is not prohibited by this part.

45 C.F.R. § 85.51(c) (1978) (*see* App. A, 4a).

Another regulation, 45 C.F.R. § 85.51(d), required "integrated" programs where appropriate. This regulation hews closely to the regulation on which the Eleventh Circuit relied:

*HEW's regulation under § 504:* Recipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons. 45 C.F.R. § 85.51(d) (1978) (*see* App. A, 4a).

*DOJ's regulation under the ADA:* A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. 28 C.F.R. § 35.130(d) (1991) (*see* App. D, 13a).

Still, no interpretation of 45 C.F.R. § 85.51(d) prior to 1990 did what the Eleventh Circuit has tried to do here. The requirement of "integrated" programs was never considered in the context of disability services for the mentally ill, but it was specifically discussed in the context of providing "equal opportunity" for handicapped persons to participate in federally assisted programs for the nonhandicapped. (43 Fed. Reg. 2132, 2134, 1-13-78) (*See* App. A, 5a). There was no hint that the integration regulation was intended to cover institutionalization or in any way affect the pace with which States provided community care. Not surprisingly, the regulation was not relied on or even discussed by the lower courts that

considered § 504 claims brought by institutionalized patients seeking treatment in the "least restrictive environment." *See* cases cited at pp. 26-27, *supra*.

**D. TITLE IIA OF THE ADA WAS A LIMITED EXTENSION OF § 504 THAT DID NOT ALTER PRIOR LAW COVERING STATE CARE FOR THE MENTALLY DISABLED.**

In adopting the ADA, Congress significantly expanded the provisions of the Rehabilitation Act regarding employment (Title I), public transportation (Title IIB), and public accommodations and services operated by private entities (Title III). By contrast, the changes to § 504 of the Rehabilitation Act, regarding public services and found in Title IIA, were minor. *See* comparison of texts at pp. 22-23, *supra*. The primary objective of the change was to extend the reach of the provision to public entities that do not receive federal funds. That change is not relevant here. The other noticeable change was to delete the word "solely" so that it no longer modifies "by reason of." But that modification, to the extent that it did anything at all, was designed simply to avoid unanticipated results. H.R. Rep. 101-485(II), \*84, 1990 U.S.C.C.A.N. 303.

There is no suggestion in these changes that Congress intended to make the broad policy changes discovered by the Eleventh Circuit. Had Congress intended the ADA significantly to alter the States' mental health care systems, surely it would not have parroted the language of § 504. Still less would it have entered the complex medical, sociological and fiscal debate about the pace and



extent of deinstitutionalization of mental health care without saying a word about the issue and without providing funding for the costs associated with such a change.

The reverberating silence of the legislative history, statement of purpose and, above all, statutory text concerning an unyielding preference for one type of mental health care over another makes plaintiffs' theory implausible. The 1990 passage of the ADA simply did not suddenly make a national value judgment in this area that all States are compelled to follow.

**E. THE GENERAL LANGUAGE OF TITLE IIA DOES NOT IMPLICITLY REPEAL OR DISPLACE THE VASTLY MORE SPECIFIC AND COMPLEX PROVISIONS OF THE MEDICAID ACT.**

Besides failing to change existing understandings of the meaning of § 504, the general terms of Title IIA of the ADA do not displace the detailed regulations established for psychiatric care by the Medicaid laws. "[W]here there is no clear intention otherwise," the Court has reminded litigants, "a specific statute will not be controlled or nullified by a general one." *Crawford Fitting Co. v. J.T. Gibbons, Inc.*, 482 U.S. 437, 445 (1987) (quoting *Radzanower v. Touche Ross & Co.*, 426 U.S. 148, 153 (1976)). Here, however, the Eleventh Circuit's interpretation of the ADA effectively displaces the excruciatingly detailed requirements of the Medicaid laws.

At the time the ADA was adopted, Medicaid funded various institutional services for the disabled. These

included nursing facility services (42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(A) (1988 & Supp. II 1990)), intermediate care facilities for the mentally retarded ("ICF/MRs") (42 U.S.C. § 1396d(a)(15) (1988)), various institutional services for the mentally ill, including inpatient psychiatric hospital services for individuals under age 21 or over age 65 (42 U.S.C. § 1396d(a)(14),-(16) (1988)), and certain institutional services for persons whose primary diagnosis is mental retardation (42 U.S.C. § 1396d(a)(1), -(4)(A), -(15) (1988 & Supp. II 1990)); 42 C.F.R. § 441.302(d)(1)-(2) (1996). See also *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998) (finding that the State must provide services in their facilities (ICF/MRs or ICF/DDs) to eligible individuals with reasonable promptness under the Medicaid Act).

Medicaid also provided funding for home and community-based care, instead of facility-based care, through its waiver programs, which the States must receive permission to offer. 42 U.S.C. § 1396n(c)(1) (1988 & Supp. II 1990). The States' discretion to choose the proper mix of Medicaid services, the Court has unanimously held, was not limited by § 504. *Alexander v. Choate*, *supra*, 469 U.S. at 302-09.

The Medicaid statute and regulations were (and still are) extremely detailed, comprehensive, and complex. They reflected a congressional policy preference for treatment in the institution over treatment in the community, and have only gradually permitted reimbursement for community care on an incremental basis. Far from requiring the States to provide treatment in "the most integrated setting appropriate," they actually required that disabled individuals *not* receive community care if they

preferred institutional care. 42 U.S.C. § 1396n(c)(2)(C) (1988). The relatively brief and general language of Title IIA cannot be read to repeal by implication these existing policies in general or the Medicaid laws and regulations in particular. *Choate*, 469 U.S. at 303.

Confirming this interpretation is the fact that Congress considered – and rejected – legislation that would have imposed an obligation on the States to provide community care at the same time that it was debating the ADA. Compare 135 Cong. Rec. S8518 (daily ed. May 9, 1989); 135 Cong. Rec. S19879 (daily ed. Sept. 7, 1989); 135 Cong. Rec. S1972 (daily ed. Feb. 8, 1989); *id.* at S1973; S. 384, 101st Cong. § 4 and § 6 (1989) with Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4712, 1990 U.S.C.C.A.N. 104 Stat. 1388-187. Congress's considered decision to reject that proposal carries great weight. See *Bob Jones Univ. v. United States*, 461 U.S. 574, 600 (1983).

**F. THE TEXT OF THE ADA DOES NOT PROVIDE THE CLEAR STATEMENT NECESSARY FOR CONGRESS TO SEIZE SUCH WIDE-RANGING, UNPREDICTABLE AND LIMITLESS CONTROL OVER A CORE AREA OF STATE AND LOCAL GOVERNMENT.**

Even if there were ambiguity regarding Congress's intentions in passing the ADA, plaintiffs' claims still must be rejected. In order to impose this kind of indeterminate and costly mandate on the States and to displace the States' traditional authority in this area, Congress must do so clearly. It has not.

As the Court has held:

"[I]f Congress intends to alter the 'usual constitutional balance between the States and the Federal Government,' it must make its intention to do so 'unmistakably clear in the language of the statute.' *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 242 (1985); see also *Pennhurst State School and Hospital v. Halderman*, 465 U.S. 89, 99 (1984)."

*Gregory v. Ashcroft*, 501 U.S. 452, 460-61 (1991) (quoting *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 65 (1989)). See also *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947) (there must be a "'clear and manifest' showing of congressional intent to supplant traditional state police powers"). There can be little doubt that a "least restrictive treatment" interpretation would alter (if not violate) the traditional constitutional balance between the States and the Federal Government and would displace the States' traditional authority in this area. And, if nothing else, the ADA, and its regulations as well, are at least ambiguous on whether a "least restrictive treatment" principle should govern services that are provided only to the disabled.

**II. THE COURT HAS APPLIED THESE PRINCIPLES BEFORE AND REJECTED A SIMILAR ARGUMENT IN PENNHURST.**

In *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), the Court applied these principles in rejecting a similar effort to alter the manner in which the States provide mental disability care to their citizens. There, as here, several patients at a State institution filed a claim to receive care in "community living arrangements." 451 U.S. at 8. There, as here, they claimed a



federal statute supported their claim – in *Pennhurst*, it was the Developmentally Disabled Assistance and Bill of Rights Act of 1975 (the “DDA”), 42 U.S.C. §§ 6000 *et seq.* (1976 & Supp. III 1979); here, it is the Americans with Disabilities Act. There, as here, the patients claimed the statute required States to provide care in the “least restrictive” environment. *Id.* at 10. And there, as here, the Court required “unmistakably clear” language establishing such a mandate before it would be willing to impose this fundamental change in the historical allocation of responsibility for psychiatric care between the State and Federal Governments. *Id.* at 24.

What differences there are between the two cases merely cement the conclusion that if it was inappropriate to impose a “least restrictive” treatment requirement under the DDA, it is doubly inappropriate to do so under the ADA. In *Pennhurst*, it could at least be claimed that there was statutory language on point, which in fact suggested that Congress meant to impose an affirmative obligation on the States in this area. After all, the DDA said that patients had “a right to appropriate treatment,” which “should be provided in the setting that is least restrictive of the person’s personal liberty.” 42 U.S.C. § 6010(1), -(2) (1976 & Supp. III 1979). Still, the Court found insufficient clarity to grant the relief. It was not clear, the Court concluded, whether these parts of the statute meant to condition the receipt of federal money on the States’ compliance with this requirement or whether the provisions merely stated a federal preference for community care rather than an obligation. 451 U.S. at 12-14. Surely if ambiguity existed in the DDA over the requirement of community care, it necessarily exists here

where there is not a word about a requirement of “least restrictive” care.

The second distinction between the *Pennhurst* statute and the ADA is again one that cuts against rather than in favor of plaintiffs’ claim. The DDA, it is true, was enacted under Congress’s spending powers. And *Pennhurst*, it is also true, concluded that Spending Clause legislation is in the nature of a Federal-State contract, requiring Congress clearly to spell out State obligations that come with accepting federal money under such programs.

But the same explanations for requiring “unmistakably clear” language in the one setting apply with equal, if not more, force in the other. Whether treated as section five legislation under the Fourteenth Amendment or Commerce Clause legislation under Article I, section 8, the ADA also imposes substantial, largely “indeterminate” obligations on the States, *Pennhurst*, 451 U.S. at 24, and does so in a setting that alters the constitutional balance between the States and Federal Government, see *Gregory v. Ashcroft*, 501 U.S. at 460-61. That Congress did so in the ADA *without providing any federal funding* does not help plaintiffs. If anything, it makes more serious the risk of allowing Congress silently to impose such massive fiscal responsibility on the States. Plainly, a clear statement rule applies in both settings. See *Gregory; Rice*. And just as Congress failed to provide the requisite “unmistakably clear” language in the DDA to require “least restrictive” treatment, so too it failed to provide the necessary clarity here.

**III. THE ELEVENTH CIRCUIT'S OPINION RESTS NOT ON THE TEXT OF THE ADA, BUT ON VAGUE STATEMENTS OF CONGRESSIONAL FINDINGS AND PURPOSE AND OF LEGISLATIVE HISTORY, AND ON A REGULATION THAT, AS INTERPRETED, EXCEEDS EXECUTIVE BRANCH POWER.**

**A. THE ELEVENTH CIRCUIT MISREAD THE TEXT OF THE ADA.**

The Eleventh Circuit's analysis does not overcome these problems. In response to the State's textual argument that plaintiffs failed to show they were discriminated against "by reason of their disability," the court merely noted that "the confinement of L.C. and E.W. at GRH-A is attributable to their disabilities, thereby proving the very element the State argues is missing." Pet. 5a. Not only does this interpretation ignore the other reasons the State has supplied for denying community care, but it would mean that all disability services are themselves discriminatory, as they are all "attributable to" disability. That belies common sense, is inconsistent with prior interpretations of § 504, and cannot be true. The Eleventh Circuit's interpretation of discrimination would lead to a regime in which the worse the disability and the greater the need for hospitalization, the stronger the case for discrimination. And, even as to hospitalized individuals who are denied community care when they are prepared for it, the denial by definition occurs in spite of disability, not because of it.

Nor was the Eleventh Circuit correct in concluding that the ADA's use of the word "institutionalization" supported this theory. Pet. 17a-18a. A reading of the cited

section *in context* shows that "institutionalization" is discrimination-neutral, just as "employment," "housing," "education," and "recreation," which are the other areas that the ADA's statement of purpose declared the statute would cover, are discrimination-neutral. 42 U.S.C. § 12101(a)(3) (1994). Cf. *Pennsylvania Dep't of Corrections v. Yeskey*, 524 U.S. \_\_\_, 118 S. Ct. 1952, 1955-56 (1998) (Court assumes that "institutionalization" may include penal institutions).

The court's repeated use of the word "confinement" to describe the plaintiffs' treatment also is exceedingly misleading. Georgia, like all States, involuntarily confines mentally ill persons only when they meet stringent statutory and constitutional standards requiring imminent risk to the patient or others due to mental illness. See *Parham v. J.R.*, 442 U.S. 584 (1979); *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Benham v. Ledbetter*, 785 F.2d 1480 (11th Cir. 1986). Such confinement is not punitive, *Addington v. Texas*, 441 U.S. 418, 428 (1979), and, until now, it was not covered by the ADA. Georgia also provides voluntary treatment to mentally ill individuals pursuant to Georgia law. O.C.G.A. § 37-3-20 (1995). But a voluntary patient who does not meet the more stringent commitment standards is not "confined" by the State. Plaintiffs were initially brought to the hospital on an involuntary basis, and after being stabilized, transferred to a voluntary basis.

Nor does it change matters that the Eleventh Circuit remanded the case to determine whether its interpretation would "fundamentally alter" the services Georgia provides. The remand incorrectly assumes that there is discrimination against plaintiffs when there is not. It mistakenly asks the district court to examine this defense



based on the cost of providing community care to just two individuals, not all Georgia citizens who desire community care. It impermissibly fails to give deference to medical and administrative judgment, by restricting state officials from considering the legitimate and traditional factors they would normally weigh in making these decisions (including the patients' and family members' preferences, quality of care, cost, and availability) and substituting therefor an overreaching commitment to least restrictive treatment. *Bowen v. American Hosp. Ass'n*, 476 U.S. 610 (1986); *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Parham v. J.R.*, 442 U.S. 584 (1979); *Jackson v. Fort Stanton Hosp. & Training Sch.*, 964 F.2d 980 (10th Cir. 1992). Thus, it fails to recognize that a decision requiring the "least restrictive" treatment will always "fundamentally alter" Georgia's provision of mental health services.

#### **B. THE LEGISLATURE DID NOT ADDRESS DEINSTITUTIONALIZATION WHEN IT ADOPTED THE ADA.**

The Eleventh Circuit's opinion also relies heavily on vague statements of Congressional findings and purposes, as well as legislative history. These statements all use the words "segregation" and "integration." Yet the court did not – and cannot – point to any such statement in the context of deinstitutionalization. The issue of deinstitutionalization, like "the dog that did not bark," simply was not before Congress, was not raised by Congress, and was not debated by Congress during the adoption of the ADA. See *Chisom v. Roemer*, 501 U.S. 380, 396 n.23 (1991).

Further, the House Education and Labor Committee Report on the ADA contradicts the Eleventh Circuit's analysis. It says that the ADA was not a departure from § 504: "The Committee intends that title II work in the same manner as § 504." H.R. Rep. 101-485(III), 101st Cong., 2d Sess. 1990, 1990 U.S.C.C.A.N. 445, 10990 WL 121680 (Leg. Hist.). Significantly,

The Committee has chosen not to list all the types of actions that are included within the term "discrimination," as was done in titles I and III, because this title essentially simply extends the antidiscrimination prohibition embodied in section 504 to all actions of state and local governments. . . . Finally, it is the Committee's intent that section 202 also be interpreted consistent with *Alexander v. Choate*, 469 U.S. 287 (1985).

H.R. Rep. No. 101-485(II), 101st Sess. 84 (1990), 1990 U.S.C.C.A.N. 267. Based on this report, Congress did not intend any broad delegation to DOJ to venture into new policy arenas such as deinstitutionalization. Further, Congress specifically endorsed the precise limitations on § 504 expressed in *Alexander v. Choate*.

The Eleventh Circuit made much of the fact that Congress required the regulations under Title IIA to be consistent with the coordination regulations originally issued by HEW. Pet. 16a. Yet this unexceptional directive merely shows that Congress intended Title IIA to be interpreted consistently with § 504, not that Congress had parsed subtle distinctions between the various agencies' regulations and favored one over the other. Indeed, the Attorney General had been directed to determine which

of the various agency regulations were "inadequate, unclear or unnecessarily inconsistent" (Exec. Order 12250, § 1-202, 45 Red. Reg. 72995, 11-4-80), and had concluded that "[d]espite the large number" of agency regulations, there was "very little variation in their substantive requirements, or even in their language." 28 C.F.R. Part 35, Supp. Info. (56 Fed. Reg. 35694, 7-26-91). Certainly Congress did not intend to favor a substantive distinction in the agency regulations so subtle that even the Attorney General did not distinguish it. The Eleventh Circuit's contrary conclusion is wrong and unsupported.

**C. THE ELEVENTH CIRCUIT GAVE IMPERMISSIBLE DEFERENCE TO THE ATTORNEY GENERAL'S INTERPRETATION OF THE INTEGRATION REGULATION.**

**1. The Attorney General's Position Is Not Based on a Permissible Interpretation of the ADA.**

The Eleventh Circuit, as well as the District Court, relied heavily on the Attorney General's *amicus* brief construing the integration regulation. The Third Circuit's opinion in *Helen L.* also adopted this position, based in part on a similar brief. The agency's interpretation of the integration regulation, however, is not based on a permissible construction of the statute. *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

Even when the Court accords the Attorney General's construction of an act deference, it does so only "if Congress has not expressed its intent with respect to the

question, and then only if the administrative interpretation is reasonable." *Reno v. Bossier Parish Sch. Bd.*, 520 U.S. 471, 483 (1997) (quoting *Presley v. Etowah County Comm'n*, 502 U.S. 491, 508 (1992)) (rejecting the Attorney General's interpretation of the Voting Rights Act); *Miller v. Johnson*, 515 U.S. 900 (1995) (same). Nothing about *Chevron* gives an Executive Branch agency authority to replace the settled Article III interpretation of a statute with a construction of its own.

**2. The Attorney General's Litigation Position Is Not Supported by Its Own Administrative Pronouncements.**

Not only is the Attorney General's position a substantial departure from settled judicial and administrative interpretations of § 504, however. It also is a dramatic departure from the agency's *own* regulations after the ADA was adopted.

In 1991, the Attorney General issued its final rules, including substantially the same "integration" provision. 28 C.F.R. Part 35 (*see* App. D, 11a). The Attorney General recognized, at least at that time, that the terms "segregation" and "integration" should be interpreted in the context of allowing disabled persons access to programs provided for the non-disabled. *See* App. D, 16a-17a.

In discussing the integration provision, the Attorney General included examples of actions that would violate the integration provision: (1) requiring a disabled person to eat in the back of a government cafeteria, or (2) requiring a blind person to go on a special museum tour instead of permitting him to tour the exhibit at his own pace with



the recorded tour. See App. D, 18a-20a. Obviously, these illustrations have no application here and simply confirm the prior interpretation of the regulation. Other provisions of the regulations are inconsistent with DOJ's current litigation position as well. See 28 C.F.R. § 35.130(c) (1991), App. D, 13a.

The Department's Technical Assistance Manual, which includes a special section on the "integrated setting" requirement, sets out over fifty examples of Title IIA's application. Not one of them, however, relates to deinstitutionalization. See *The Americans With Disabilities Act, Title II Technical Assistance Manual, Covering State and Local Government Programs and Services*, 1993 edition.

The Attorney General's present litigation position in the end represents a stark and unexplained departure from prior interpretations of § 504 and the ADA. This departure was not justified by any re-examination of the complex issues or consideration of the competing policies at stake. *Chevron*, 467 U.S. at 857-58. The change appears to have occurred entirely outside the ongoing national debate on the issue. It is a mere "litigation position" and is without the usual justifications for deference to an agency's interpretation. *Gregory v. Ashcroft*, 501 U.S. 452, 485 n.3 (1991) (White, J., concurring in judgment). At any rate, DOJ is not an agency with expertise in mental health care, and its new position was not adopted pursuant to notice and comment under the Administrative Procedures Act. See *Paralyzed Veterans of America v. D. C. Arena L.P.*, 117 F.3d 579, 586 (D.C. Cir. 1997).

### 3. The Attorney General's Position Raises Serious Constitutional Problems.

Statutory or regulatory interpretations that create constitutional doubt should be avoided. *United States ex rel. Attorney General v. Delaware & Hudson Co.*, 213 U.S. 366, 408 (1909). The Eleventh Circuit's opinion raises serious doubt on at least two fronts.

First, the Eleventh Circuit found that any ambiguity in the statutory text about deinstitutionalization could be resolved by delegating broad, policy-making authority to the Attorney General. Pet. 6a-7a. This approach, of course, violates the clear-statement requirement of *Pennhurst* and *Gregory*. The Constitution does not permit Congress to delegate authority to the Executive Branch to decide when, where, and whether to divest the States of authority, and to do so in such an indeterminate and unguided way. Unlike the customary *Chevron* situation, Congress did not leave an explicit gap in the statute for interpretation by the Department of Justice. To the contrary, in its House Report Congress expressly limited Title IIA's definition of "discrimination" to its previous interpretations under § 504. See *supra*.

Such hidden appropriations of authority cannot be squared with one of the central justifications for allowing regulation of the States in the first instance. The principal explanation for *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528 (1985) – that States protect their self-interest through representatives in Congress – is of no help here. The States have no representative in the Executive Branch, and at any rate had no opportunity to influence this re-interpretation of the regulations, since

no public hearings were held. If the States, in short, must be held accountable for exercising or declining to exercise their political muscle in the halls of Congress, then surely Congress must be precluded from seizing such power silently or, worse, leaving it to the whim of an executive branch where the States have no representation.

Nor may plaintiffs end-run the clear-statement requirement by arguing that Congress (and presumably the States) are aware that ambiguities in a statute will be resolved by the implementing agency. *Chevron*, 467 U.S. at 842-43. Such default rules do not trump the time-honored clear-statement rule, which requires statutory ambiguity to be construed in favor of preserving traditional State authority, not of displacing it.

A second area of constitutional doubt raised by the Eleventh Circuit's interpretation is whether the Attorney General's position exceeds Congressional authority under § 5 of the Fourteenth Amendment. *See* Pet. 12-16. *See also Kimel v. State of Florida Bd. of Regents*, 157 F.3d 908 (11th Cir. 1998), *cert. granted*, No. 98-791, 98-796 (Jan. 25, 1999) (limited to the ADEA), *cert. pending*, No. 98-829 (ADA); *Kilcullen v. New York State Dep't of Transp.*, 1999 U.S. Dist. LEXIS 438 (N.D.N.Y. 1999). In light of the lack of support for the Eleventh Circuit's interpretation in either the plain text of the statute, the settled interpretation of § 504, or the legislative history, these areas of constitutional doubt can and should be avoided.

---

## CONCLUSION

For the foregoing reasons, the Eleventh Circuit's decision should be reversed.

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## INDEX TO APPENDIX

|  | Page |
|--|------|
| APPENDIX A COORDINATION REGULATIONS<br>ISSUED BY THE DEPARTMENT<br>OF HEALTH, EDUCATION AND<br>WELFARE |      |
| 45 C.F.R. Part 85 (43 Fed. Reg.<br>2132, 1-13-78).....   | 1a   |
| APPENDIX B REDESIGNATION AND TRANS-<br>FER OF § 504 GUIDELINES   |      |
| 28 C.F.R. Part 41, 45 C.F.R. Part 85<br>(43 Fed. Reg. 40686, 8-11-81).....                             | 6a   |
| APPENDIX C TITLE II A OF THE AMERICANS<br>WITH DISABILITIES ACT OF<br>1990                             |      |
| 42 U.S.C. §§ 12131-12134 (Supp.<br>1990).....  | 7a   |
| APPENDIX D COORDINATION REGULATIONS<br>ISSUED BY THE DEPARTMENT<br>OF JUSTICE                          |      |
| 28 C.F.R. Part 35 (56 Fed. Reg.<br>35694, 7-26-91).....  | 10a  |

**APPENDIX A**  
**COORDINATION REGULATIONS ISSUED**  
**BY THE DEPARTMENT OF HEALTH,**  
**EDUCATION, AND WELFARE**

45 C.F.R. Part 85 (43 Fed. Reg. 2132, 1-13-78)

Implementation of Executive Order 11914, Non-discrimination On The Basis Of Handicap In Federally Assisted Programs

[Final rule by Department of Health, Education and Welfare]

**SUMMARY:** This rule implements Executive Order 11914, "Nondiscrimination with Respect to the Handicapped In Federally Assisted Programs," under which the Department of Health, Education, and Welfare is required to coordinate government wide enforcement of section 504 of the Rehabilitation Act of 1973, as amended. In particular, the rule sets forth enforcement procedures, standards for determining which persons are handicapped, and guidelines for determining what practices are discriminatory. These procedures, standards, and guidelines are to be followed by each federal agency that provides federal financial assistance in issuing regulations implementing section 504.

\* \* \*

**SUBPART C - Guidelines for Determining Discriminatory Practices**

**GENERAL**

§ 85.51 General prohibitions against discrimination.

(a) No qualified handicapped person, shall, on the basis of handicap, be excluded from participation in, be



denied the benefits of, or otherwise be subjected to discrimination under any program or activity that receives or benefits from federal financial assistance.

(b)(1) A recipient, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of handicap:

(i) Deny a qualified handicapped person the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified handicapped person an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified handicapped person with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aid, benefits, or services to handicapped persons or to any class of handicapped persons than is provided to others unless such action is necessary to provide qualified handicapped persons with aid, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified handicapped person by providing significant assistance to an agency, organization, or person that discriminates on the basis of handicap in providing any aid, benefit, or service to beneficiaries of the recipient's program;

(vi) Deny a qualified handicapped person the opportunity to participate as a member of planning or advisory boards; or

(vii) Otherwise limit a qualified handicapped person in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

(2) A recipient may not deny a qualified handicapped person the opportunity to participate in programs or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) A recipient may not, directly or through contractual or other arrangements, utilize criteria or methods of administration (i) that have the effect of subjecting qualified handicapped persons to discrimination on the basis of handicap, (ii) that have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the recipient's program with respect to handicapped persons, or (iii) that perpetuate the discrimination of another recipient if both recipients are subject to common administrative control or are agencies of the same state.

(4) A recipient may not, in determining the site or location of a facility, make selections (i) that have the effect of excluding handicapped persons from, denying them the benefits of, or otherwise subjecting them to discrimination under any program or activity that receives or benefits from federal financial assistance or (ii) that have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives

of the program or activity with respect to handicapped persons.

(c) The exclusion of nonhandicapped persons from the benefits of a program limited by federal statute or executive order to handicapped persons or the exclusion of a specific class of handicapped persons from a program limited by federal statute or executive order to a different class of handicapped persons is not prohibited by this part.

(d) Recipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.

(e) Recipients shall take appropriate steps to ensure that communications with their applicants, employees, and beneficiaries are available to persons with impaired vision and hearing.

\* \* \*

#### SUPPLEMENTARY INFORMATION

\* \* \*

Subpart C of this regulation, sets forth guidelines for determining discriminatory practices; these are, in general, minimum requirements. Except where obvious discrepancies in implementation would result, other agencies may exceed these standards if they wish. The subpart is divided into three parts: General, based on § 84.4 of the HEW section 504 regulation; Employment, based on Subpart B of the HEW section 504 regulation, and Program Accessibility, based on Subpart C the HEW section 504 regulation. A more detailed discussion of

these subparts than is contained below may be found in Appendix A of the HEW regulation.

The general prohibitions against discrimination on the basis of handicap set forth in § 85.51 incorporate basic principles that the Department determined, in developing its own regulation, to be inherent in section 504. First, section 504, like other nondiscrimination statutes, prohibits not only those practices that are overtly discriminatory but also those that have the effect of discriminating. And it is equal opportunity, not merely equal treatment, that is essential to the elimination of discrimination on the basis of handicap. Thus, in some situations, identical treatment of handicapped and nonhandicapped persons is not only insufficient but is itself discriminatory. On the other hand, separate or different treatment can be permitted only where necessary to ensure equal opportunity and truly effective benefits and services. Federally assisted programs and activities must thus be provided in the most integrated setting appropriate to the needs of participating handicapped persons.

[Dated January 13, 1978. Joseph A. Califano, Jr., Secretary.]

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**APPENDIX B**  
**REDESIGNATION AND TRANSFER OF**  
**§ 504 GUIDELINES**

28 C.F.R. Part 41, 45 C.F.R. Part 85 (43 Fed. Reg. 40686, 8-11-81)

[Final Rule by Department of Justice]

\* \* \*

This rule is issued pursuant to section 1-303 of Executive Order 12250 which provides that in carrying out his functions under the Order the Attorney General shall issue such regulations "as he deems necessary". The rule will retitle the present guidelines at 45 C.F.R. Part 85, transfer them to 28 C.F.R. Part 41, and make necessary nomenclature changes.

Publication of this rule as a proposal for public comment is unnecessary since it is solely a redesignation of existing regulations.

\* \* \*

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**APPENDIX C**  
**TITLE IIA OF THE AMERICANS WITH**  
**DISABILITIES ACT OF 1990**

42 U.S.C. §§ 12131-12134 (Supp. 1990)

**SUBCHAPTER II-PUBLIC SERVICES**

Part A-Prohibition Against Discrimination and Other Generally Applicable Provisions

§ 12131. Definitions

As used in this subchapter:

(1) Public entity

The term "public entity" means-

(A) any State or local government;

(B) any department, agency, special purpose district, or other instrumentality of a State or States or local government; and

(C) the National Railroad Passenger Corporation, and any commuter authority (as defined in section 502(8) of title 45).

(2) Qualified individual with a disability

The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

### § 12132. Discrimination

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

### § 12133. Enforcement

The remedies, procedures, and rights set forth in section 794a of title 29 shall be the remedies, procedures, and rights this subchapter provides to any person alleging discrimination on the basis of disability in violation of section 12132 of this title.

### § 12134. Regulations

#### (a) In general

Not later than 1 year after July 26, 1990, the Attorney General shall promulgate regulations in an accessible format that implement this part. Such regulations shall not include any matter within the scope of the authority of the Secretary of Transportation under section 12143, 12149, or 12164 of this title.

#### (b) Relationship to other regulations

Except for "program accessibility, existing facilities", and "communications", regulations under subsection (a) of this section shall be consistent with this chapter and with the coordination regulations under part 41 of title 28, Code of Federal Regulations (as promulgated by the Department of Health, Education, and Welfare on January 13, 1978), applicable to recipients of Federal financial

assistance under section 794 of title 29. With respect to "program accessibility, existing facilities", and "communications", such regulations shall be consistent with regulations and analysis as in part 39 of title 28 of the Code of Federal Regulations, applicable to federally conducted activities under section 794 of title 29.

#### (c) Standards

Regulations under subsection (a) of this section shall include standards applicable to facilities and vehicles covered by this part, other than facilities, stations, rail passenger cars, and vehicles covered by part B of this subchapter. Such standards shall be consistent with the minimum guidelines and requirements issued by the Architectural and Transportation Barriers Compliance Board in accordance with section 12204(a) of this title.

[Editorial notes, including cross-references, citations to statute, and effective date, omitted throughout]

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## APPENDIX D

COORDINATION REGULATIONS ISSUED BY THE  
DEPARTMENT OF JUSTICE

28 C.F.R. Part 35 (56 Fed. Reg. 35694, 7-26-91)

Nondiscrimination on the Basis of Disability in State and  
Local Government Services

[Final Rule By Department of Justice]

\* \* \*

## SUBPART B - GENERAL REQUIREMENTS

## § 35.130 General prohibitions against discrimination

(a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subject to discrimination by any public entity.

(b)(1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability -

(i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

(vi) Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

(vii) Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit or service.

(2) A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

(i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;

(ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or

(iii) That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.

(4) A public entity may not, in determining the site or location of a facility, make selections-

(i) that have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or

(ii) that have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.

(5) A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.

(6) A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the program or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.

(7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

(8) A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.

(c) Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.

(d) A public entity shall administer services, programs, and activities in the most integrated setting



appropriate to the needs of qualified individuals with disabilities.

(e)(1) Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

(2) Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

(f) A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

(g) A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

\* \* \*

#### SUPPLEMENTARY INFORMATION

[56 Fed. Reg. 35694, 7-26-91]

The landmark Americans with Disabilities Act ("ADA" or "the Act"), enacted on July 26, 1990, provides

comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, State and local government services, and telecommunications.

This regulation implements subtitle A of title II of the ADA, which applies to State and local governments. Most programs and activities of State and local governments are recipients of Federal financial assistance from one or more Federal funding agencies, and therefore, are already covered by section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794) ("section 504"), which prohibits discrimination on the basis of handicap in federally assisted programs and activities. Because title II of the ADA essentially extends the nondiscrimination mandate of section 504 to those State and local governments that do not receive Federal financial assistance, this rule hews closely to the provisions of existing section 504 regulations. This approach is also based on section 204 of the ADA, which provides that the regulations issued by the Attorney General to implement title II shall be consistent with the ADA and with the Department of Health, Education and Welfare's coordination regulation, now codified at 28 C.F.R. part 41, and, with respect to "program accessibility, existing facilities," and "communications," with the Department of Justice's regulation for its federally conducted programs and activities, codified at 28 C.F.R. part 39.

\* \* \*

## SECTION BY SECTION ANALYSIS

[now printed at 28 C.F.R. Part 35, Appendix A]

[emphasis added]

\* \* \*

Paragraph (a) [of § 35.130] restates the non-discrimination mandate of section 202 of the ADA. The remaining paragraphs in § 35.130 establish the general principles for analyzing whether any particular action of the public entity violates this mandate.

Paragraph (b) prohibits overt denials of equal treatment of individuals with disabilities. A public entity may not refuse to provide an individual with a disability with an equal opportunity to participate in or benefit from its program simply because the person has a disability.

Paragraph (b)(1)(i) provides that it is discriminatory to deny a person with a disability the right to participate in or benefit from the aid, benefit or service provided by a public entity. Paragraph (b)(1)(ii) provides that the aids, benefits, and services provided to persons with disabilities must be equal to those provided to others, and paragraph (b)(1)(iii) requires that the aids, benefits, or services provided to individuals with disabilities must be as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as those provided to others. These paragraphs are taken from the regulations implementing section 504 and simply restate principles long established under section 504.

Paragraph (b)(1)(iv) permits the public entity to develop separate or different aids, benefits, or services

when necessary to provide individuals with disabilities with an equal opportunity to participate in or benefit from the public entity's programs or activities, but only when necessary to ensure that the aids, benefits, or services are as effective as those provided to others. Paragraph (b)(1)(iv) must be read in conjunction with paragraphs (b)(2), (d), and (e). Even when separate or different aids, benefits, or services would be more effective, paragraph (b)(2) provides that a qualified individual with a disability still has the right to choose to participate in the program that is not designed to accommodate individuals with disabilities. Paragraph (d) requires that a public entity administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Paragraph (b)(2) specifies that, notwithstanding the existence of separate or different programs or activities provided in accordance with this section, an individual with a disability shall not be denied the opportunity to participate in such programs or activities that are not separate or different. Paragraph (e), which is derived from section 501(d) of the Americans with Disabilities Act, states that nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit that he or she chooses not to accept.

Taken together, these provisions are intended to prohibit exclusion and *segregation* of individuals with disabilities and the denial of equal opportunities enjoyed by others, based on, among other things, presumptions, patronizing attitudes, fears, and stereotypes about individuals with disabilities. Consistent with these standards,



public entities are required to ensure that their actions are based on facts applicable to individuals and not on presumptions as to what a class of individuals with disabilities can or cannot do.

*Integration* is fundamental to the purposes of the Americans with Disabilities Act. Provision of segregated accommodations and services relegates persons with disabilities to second-class status. *For example*, it would be a violation of this provision to require persons with disabilities to eat in the back room of a government cafeteria or to refuse to allow a person with a disability the full use of recreation or exercise facilities because of stereotypes about the person's ability to participate.

Many commenters objected to proposed paragraphs (b)(1)(iv) and (d) as allowing continued *segregation* of individuals with disabilities. The Department recognizes that promoting integration of individuals with disabilities into the mainstream of society is an important objective of the ADA and agrees that, in most instances, separate programs for individuals with disabilities will not be permitted. Nevertheless, section 504 does permit separate programs in limited circumstances, and Congress clearly intended the regulations issued under title II to adopt the standards of section 504. Furthermore, Congress included authority for separate programs in the specific requirements of title III of the Act. Section 302(b)(1)(A)(iii) of the Act provides for separate benefits in language similar to that in § 35.130(b)(1)(iv), and section 302(b)(1)(B) includes the same requirement for "the most *integrated* setting appropriate" as in § 35.130(d).

Even when separate programs are permitted, individuals with disabilities cannot be denied the opportunity to participate in programs that are not separate or different. This is an important and overarching principle of the Americans with Disabilities Act. Separate, special, or different programs that are designed to provide a benefit to persons with disabilities cannot be used to restrict the participation of person with disabilities in general, *integrated* activities.

*For example*, a person who is blind may wish to decline participating in a special museum tour that allows persons to touch sculptures in an exhibit and instead tour the exhibit at his or her own pace with the museum's recorded tour. It is not the intent of this section to require the person who is blind to avail himself or herself of the special tour. Modified participation for persons with disabilities must be a choice, not a requirement.

In addition, it would not be a violation of this section for a public entity to offer recreational programs specially designed for children with mobility impairments. However, it would be a violation of this section if the entity then excluded these children from other recreational services for which they are qualified to participate when these services are made available to nondisabled children, or if the entity required children with disabilities to attend only designated programs.

Many commenters asked that the Department clarify a public entity's obligation within the *integrated* program when it offers a separate program but an individual with a disability chooses not to participate in the separate

program. It is impossible to make a blanket statement as to what level of auxiliary aids or modifications would be required in the *integrated* program. Rather, each situation must be assessed individually. The starting point is to question whether the separate program is in fact necessary or appropriate for the individual. Assuming the separate program would be appropriate for a particular individual, the extent to which that individual must be provided with modifications in the *integrated* program will depend not only on what the individual needs but also on the limitations and defenses of this part. *For example*, it may constitute an undue burden for a public accommodation which provides a full-time interpreter in its special guided tour for individuals with hearing impairments, to hire an additional interpreter for those individuals who choose to attend the integrated program. The Department cannot identify categorically the level of assistance or aid required in the integrated program.

Paragraph (b)(7) is a specific application of the requirement under the general prohibitions of discrimination that public entities make reasonable modifications in policies, practices, or procedures where necessary to avoid discrimination on the basis of disability. Section 302(b)(2)(A)(ii) of the ADA sets out this requirement specifically for public accommodations covered by title III of the Act, and the House Judiciary Committee Report directs the Attorney General to include those specific requirements in the title II regulation to the extent that they do not conflict with the regulations implementing section 504. Judiciary report at 52.

Paragraph (c) provides that nothing in this part prohibits a public entity from providing benefits, services, or

advantages to individuals with disabilities, or to a particular class of individuals with disabilities, beyond those required by this part. It is derived from a provision in the section 504 regulations that permits programs conducted pursuant to Federal statute or Executive order that are designed to benefit only individuals with disabilities or a given class of individuals with disabilities to be limited to those individuals with disabilities. Section 504 ensures that federally assisted programs are made available to all individuals, without regard to disabilities, unless the Federal program under which the assistance is provided is specifically limited to individuals with disabilities or a particular class of individuals with disabilities. Because coverage under this part is not limited to federally assisted programs, paragraph (c) has been revised to clarify that State and local governments may provide special benefits, beyond those required by the non-discrimination requirements of this part, that are limited to individuals with disabilities or a particular class of individuals with disabilities, without thereby incurring additional obligations to persons without disabilities or to other classes of individuals with disabilities.

Paragraphs (d) and (e), previously referred to in the discussion of paragraph (b)(1)(iv), provide that the public entity must administer services, programs, and activities in the most integrated setting appropriate to the needs or qualified individuals with disabilities, i.e., in a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible, and that persons with disabilities must be provided the option of declining to accept a particular accommodation.

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IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1998

TOMMY OLMSTEAD, Commissioner, Georgia  
Department of Human Resources, *et al.*,  
v. *Petitioners,*

L.C., by JONATHAN ZIMRING,  
Guardian Ad Litem and Next Friend, *et al.*,  
*Respondents.*

On Writ of Certiorari to the  
United States Court of Appeals  
for the Eleventh Circuit

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## **COUNTER-STATEMENT OF THE QUESTION PRESENTED**

Does a plaintiff establish a prima facie case of discrimination, violative of the Americans with Disabilities Act, by showing that (1) a public entity administers a unified program of services for persons with mental disability, including treatment both in mental institutions and in the community, (2) the public entity's professionals have determined that the plaintiff can appropriately be provided the services in the community, where the plaintiff would enjoy meaningful opportunity to interact with nondisabled persons and participate in the economic and social life of the community, but (3) the public entity will furnish plaintiff the services only if she lives in a mental institution, thereby segregated from the community?

[The court below held, first, that the answer to this question is yes, but, second, that a public entity enjoys a defense to this requirement upon a showing that compliance would require a fundamental alteration in its services, programs or activities. Petitioners have brought the first of these holdings to this Court for review, but not the second.]



## TABLE OF CONTENTS

|   | Page |
|---|------|
| COUNTER-STATEMENT OF THE QUESTION PRESENTED .....   | i    |
| TABLE OF AUTHORITIES .....  | vi   |
| ADDITIONAL STATUTORY AND REGULATORY PROVISIONS .....  | 1    |
| COUNTER-STATEMENT OF THE CASE .....   | 1    |
| I. The History of Institutionalization of Persons with Mental Disabilities .....  | 1    |
| II. The National Shift to Community-Based Services and Georgia's Resistance .....   | 3    |
| III. The Respondents .....  | 5    |
| A. L.C. ....  | 5    |
| B. E.W. ....  | 7    |
| IV. The Relative Access to the Community at Large of Those Who Are Institutionalized and Those Who Receive Services in the Community .....                              | 8    |
| V. Cost Is Not the Reason Respondents Were Denied Services in the Community .....   | 9    |
| VI. The Rulings Below .....   | 11   |
| VII. Sharpening and Narrowing the Issue Presented .....   | 13   |
| INTRODUCTION AND SUMMARY OF ARGUMENT .....  | 15   |
| ARGUMENT .....  | 17   |
| I. APPLYING THE CUSTOMARY TOOLS OF STATUTORY CONSTRUCTION, THE ADA BANS ADMINISTRATION OF SERVICES, PROGRAMS, AND ACTIVITIES IN UNNECESSARILY SEGREGATIVE SETTINGS..... | 17   |

## TABLE OF CONTENTS—Continued

|  | Page |
|--|------|
| A. The Text .....  | 17   |
| 1. "Discrimination. . . ." .....   | 17   |
| 2. ". . . . By Reason of Disability" .....   | 22   |
| B. The Legislative History .....   | 25   |
| 1. The Hearings .....  | 25   |
| 2. The Committee Reports .....   | 27   |
| 3. The Floor Debates .....   | 30   |
| C. The Lessons of the Text and Legislative History .....   | 31   |
| D. Petitioners' Contrary Account .....   | 32   |
| 1. The Chafee Bill .....   | 32   |
| 2. The Attorney General's Section by Section Analysis .....  | 34   |
| E. The Attorney General's Consistent Interpretation of the ADA .....   | 34   |
| F. Petitioner's Invocation of <i>Gregory v. Ashcroft</i> .....   | 36   |
| II. PETITIONERS' ARGUMENTS—THAT CONGRESS COULD NOT HAVE INTENDED WHAT THE STATUTE PLAINLY SAYS—ARE UNPERSUASIVE .....  | 38   |
| A. "THE DOG THAT DIDN'T BARK:" The Contention That the History of Implementation of Section 504 of the Rehabilitation Act Shows That Congress Did Not Intend the "Most Integrated Setting" Command of the ADA to Apply to Disability-Only Services.... | 38   |
| 1. Petitioners' Account of the Enforcement of § 504 Is Wrong .....   | 39   |
| 2. Petitioners' Assumption That the Text of the ADA Is the Same as § 504 Is Wrong .....  | 42   |

## TABLE OF CONTENTS—Continued

|  | Page |
|--|------|
| 3. Petitioners' Assumption That the § 504 Coordination Regulations Were at Issue in the Pre-ADA Cases Is Wrong .....   | 43   |
| B. "PENNHRUST LITE:" The Contention That This Court's Decision in Pennhurst Controls the Disposition of This Case .....  | 44   |
| C. "THE SKY IS FALLING:" The Contention That Congress Could Not Have Intended, Without Clearer Articulation, to Have Imposed on the States Massive Fiscal and Administrative Burdens ..... | 47   |
| D. Avoiding Constitutional Questions .....   | 50   |
| CONCLUSION .....   | 50   |
| APPENDIX .....   | 1a   |



## TABLE OF AUTHORITIES

| CASES:  | Page       |
|---|------------|
| <i>ADAPT v. Skinner</i> , 881 F.2d 1184 (3rd Cir. 1989) ( <i>en banc</i> ) .....  | 43         |
| <i>Alexander v. Choate</i> , 469 U.S. 287 (1985) .....  | 20, 23, 41 |
| <i>Auer v. Robbins</i> , 117 S. Ct. 905 (1997) .....  | 35         |
| <i>Bragdon v. Abbott</i> , 118 S. Ct. 2196 (1998) .....   | 14         |
| <i>Cedar Rapids Community School District v. Garret</i><br>F, No. 96-1793, 1999 WL 104410 (U.S. Mar. 3,<br>1999) .....  | 46         |
| <i>Chevron U.S.A. v. National Resource Defense</i><br><i>Council, Inc.</i> , 467 U.S. 837 (1984) .....  | 35         |
| <i>Clark v. Cohen</i> , 794 F.2d 69 (3d Cir. 1985), <i>cert.</i><br><i>denied</i> , 479 U.S. 962 (1986) .....   | 44         |
| <i>City of Cleburne v. Cleburne Living Center</i> , 473<br>U.S. 432 (1985) .....  | 2, 48, 50  |
| <i>Connecticut v. Teal</i> , 457 U.S. 440 (1982) .....  | 38         |
| <i>Dothard v. Rawlinson</i> , 433 U.S. 321 (1977) .....   | 38         |
| <i>Etheridge v. Charter Peachford Hospital</i> , 436<br>S.E.2d 669 (Ga. App. 1993) .....  | 8          |
| <i>Gregory v. Ashcroft</i> , 501 U.S. 452 (1991) .....  | 36, 37     |
| <i>Griggs v. Duke Power Co.</i> , 401 U.S. 424 (1971) .....   | 38         |
| <i>Halderman v. Pennhurst State School &amp; Hospital</i> ,<br>446 F. Supp. 1295 (E.D. Pa. 1977) .....  | 39, 41     |
| <i>Halderman v. Pennhurst State School &amp; Hospital</i> ,<br>612 F.2d 84 (3rd Cir. 1979) .....  | 40         |
| <i>Halderman v. Pennhurst State School &amp; Hospital</i> ,<br>673 F.2d 647 (3rd Cir. 1982) .....   | 40         |
| <i>Helen L. v. DiDario</i> , 46 F.3d 325 (3d Cir. 1995),<br><i>cert. denied</i> , 516 U.S. 813 (1995) .....   | 16, 35, 44 |
| <i>Homeward Bound, Inc. v. Hissom Memorial Cen-</i><br><i>ter</i> , No. 85-C-437-E, 1987 WL 27104 (N.D. Okla.<br>July 24, 1987) .....   | 41         |
| <i>Jackson v. Fort Stanton Hospital &amp; Training</i><br><i>School</i> , 757 F. Supp. 1243 (D.N.M. 1990), <i>rev'd</i><br><i>on other grounds</i> , 964 F.2d 980 (10th Cir.<br>1992) ..... | 41         |
| <i>Kentucky Association for Retarded Citizens v.</i><br><i>Conn.</i> , Civ. Ac. No. C-78-0157-L(A) (W.D. Ky.<br>Filed June 18, 1979) .....  | 39         |
| <i>Lynch v. Maher</i> , 507 F. Supp. 1268 (D. Conn.<br>1981) .....  | 41         |

## TABLE OF AUTHORITIES—Continued

|   | Page             |
|---|------------------|
| <i>Martin v. OSHA</i> , 499 U.S. 144 (1991) .....   | 35               |
| <i>McNamara v. Dukakis</i> , 1990 WL 235439 (D. Mass.<br>1990) .....  | 8                |
| <i>P.C. v. McLaughlin</i> , 913 F.2d 1033 (2d Cir. 1990) ..   | 41               |
| <i>Pennhurst State School &amp; Hospital v. Halderman</i> ,<br>451 U.S. 1 (1981) .....                                      | 3, 39, 40, 44-46 |
| <i>Pennhurst State School &amp; Hospital v. Halderman</i> ,<br>465 U.S. 89 (1984) .....                                     | 40               |
| <i>Pennsylvania Department of Corrections v. Yeskey</i> ,<br>118 S. Ct. 1952 (1998) .....                                   | 37               |
| <i>People First of Tennessee v. Arlington Develop-</i><br><i>mental Center</i> , 878 F. Supp. 97 (W.D. Tenn.<br>1992) ..... | 41               |
| <i>Rust v. Sullivan</i> , 500 U.S. 173 (1991) .....   | 35               |
| <i>School Board of Nassau County v. Arline</i> , 480 U.S.<br>273 (1987) .....   | 14               |
| <i>Sedima, SPRL v. Imrex Co.</i> , 473 U.S. 479 (1985) ..   | 37               |
| <i>S.H. and P.F. v. Edwards</i> , 886 F.2d 292 (11th Cir.<br>1989) .....  | 4, 44            |
| <i>Southeastern Community College v. Davis</i> , 442<br>U.S. 397 (1979) .....   | 40, 41           |
| <i>Thomas Jefferson University v. Shalala</i> , 512 U.S.<br>504 (1994) .....  | 34, 35           |
| <i>United States v. Alaska</i> , 503 U.S. 569 (1992) .....  | 35               |
| <i>United States v. Board of Commissioners of Shef-</i><br><i>field, Alabama</i> , 435 U.S. 110 (1978) .....                | 20               |
| <i>Wyatt v. Hardin</i> , Civ. Ac. No. 3195-N (N.D. Ala.<br>1979) .....  | 39               |
| <i>Wyatt v. Poundstone</i> , 892 F. Supp. 1410 (M.D. Ala.<br>1995) .....  | 8                |

## STATUTES, RULES AND REGULATIONS:

|   |                   |
|---|-------------------|
| Title VII of the Civil Rights Act of 1964 .....                         | 38                |
| The Developmentally Disabled Assistance and Bill<br>of Rights Act ..... | 39, 40, 45        |
| Title I of the Americans with Disabilities Act .....                    | 13, 19, 23        |
| Title II of the Americans with Disabilities Act .....                   | passim            |
| Title III of the Americans with Disabilities Act .....                  | 12, 19,<br>21, 23 |

## TABLE OF AUTHORITIES—Continued

|   | Page                   |
|---|------------------------|
| 29 U.S.C. § 794, Section 504 of the Rehabilitation Act of 1973 .....                            | <i>passim</i>          |
| 42 U.S.C. § 12101, Section 2 of the Americans with Disabilities Act .....                       | 1, 17, 18, 21, 42, 50  |
| 42 U.S.C. § 12132, Section 202 of the Americans with Disabilities Act .....                     | 17, 18, 22, 42         |
| 42 U.S.C. § 12134, Section 204 of the Americans with Disabilities Act .....                     | 12, 18, 19, 20, 23, 43 |
| 42 U.S.C. § 12202, Section 502 of the Americans with Disabilities Act .....                     | 37                     |
| Section 302(b) (1) (B) of the Americans with Disabilities Act .....                             | 21                     |
| 42 U.S.C. § 1396a(a) (10) (B) .....   | 3                      |
| 42 U.S.C. § 1396d(a) (14), (16) .....   | 3                      |
| 42 U.S.C. § 1396d(a) (27) (B) .....   | 3                      |
| 42 U.S.C. § 1396n(c) (3) .....  | 3                      |
| Pub. L. No. 95-35, § 2176, 95 Stat. 357 (1981) (codified as amended at 42 U.S.C. § 1396n(c)) .. | 3                      |
| Pub. L. No. 99-509, § 9411, 100 Stat. 1874 (1986) ..  | 3                      |
| 28 C.F.R. § 35.130 .....  | 1, 22                  |
| 28 C.F.R. § 35.130(a) .....   | 22                     |
| 28 C.F.R. § 35.130(b) .....   | 22, 34, 43             |
| 28 C.F.R. § 35.130(c) .....   | 22                     |
| 28 C.F.R. § 35.130(d) .....   | <i>passim</i>          |
| 28 C.F.R. § 35.130(e) .....   | 14                     |
| 28 C.F.R. Part 41 .....   | 23, 43                 |
| 28 C.F.R. § 41.51(d) .....  | 12, 20                 |
| 42 C.F.R. § 440.240(b) .....  | 3                      |
| 45 C.F.R. Part 84 .....   | 43                     |
| 45 C.F.R. Part 85 .....   | 43                     |
| 45 C.F.R. § 84.4 .....  | 43, 44                 |
| 56 Fed. Reg. 35705 (July 26, 1991) .....  | 22                     |
| O.C.G.A. § 37-2-5.1(C) (3) .....  | 5                      |
| O.C.G.A. § 37-2-5.2(A) (5) .....  | 5                      |
| O.C.G.A. § 37-3-22 .....  | 8                      |
| 1918 Ga. Laws 921 .....   | 2                      |
| 1919 Ga. Laws 377 .....   | 2                      |
| 1937 Ga. Laws 414 .....   | 2                      |
| 1970 Ga. Laws 683 .....   | 2                      |

## TABLE OF AUTHORITIES—Continued

| OTHER AUTHORITIES:   | Page                       |
|--|----------------------------|
| 135 Cong. Rec. 1960-71 (February 8, 1989) .....  | 33                         |
| 135 Cong. Rec. S4986 (daily ed. May 9, 1989) .....   | 18, 30                     |
| 135 Cong. Rec. S4993 (daily ed. May 9, 1989) .....   | 30                         |
| 135 Cong. Rec. 8518 (May 9, 1989) .....  | 33                         |
| 135 Cong. Rec. 8519 (May 9, 1989) .....  | 33                         |
| 135 Cong. Rec. S10713 (daily ed. Sept. 7, 1989) .....  | 30                         |
| 135 Cong. Rec. 19835 (1989) .....  | 49                         |
| 136 Cong. Rec. H2447 (daily ed. May 17, 1990) .....  | 30                         |
| S. Rep. No. 101-116, 101st Cong., 1st Sess. (1989) ..  | 19, 23, 25, 27, 28, 29, 42 |
| H. Rep. No. 101-485, pt. 1, 101st Cong., 2d Sess. (1990) .....   | 27, 28, 29                 |
| H. Rep. No. 101-485, pt. 2, 101st Cong., 2d Sess. (1990) .....   | 19, 23, 27, 28, 29, 42     |
| H. Rep. No. 101-485, pt. 3, 101st Cong., 2d Sess. (1990) .....   | 19, 23, 25, 27, 28         |
| H. Rep. No. 101-485, pt. 4, 101st Cong., 2d Sess. (1990) .....   | 27, 29, 42                 |
| Americans with Dissabilities Act, Hearing Before the Senate Committee on Labor & Human Resources and the Sub-committee on the Handicapped, 101st Congress, 1st Session (1989) .....                                      | 25, 42                     |
| National Council on Disability, <i>Equality of Opportunity: The Making of the Americans with Disabilities Act (1997)</i> .....   | 31                         |
| Oversight Hearing on H.R. 4498, <i>Americans with Disabilities Act of 1988: Hearings Before the Subcommittee on Select Education of the House Committee on Education &amp; Labor, 100th Cong., 2d Sess. (1988)</i> ..... | 25, 26                     |
| Staff of House Committee on Education & Labor, 101st Cong., 2d Sess., Report on P.L. 101-336, <i>Legislative History of the Americans with Disabilities Act (Comm. Print 1990)</i> .....                                 | 26                         |
| U.S. Commission on Civil Rights, <i>Accommodating the Spectrum of Individual Abilities (1983)</i> ..   | 1, 2, 9, 28, 29            |



TABLE OF AUTHORITIES—Continued

|   | Page |
|---|------|
| United States Department of Health & Human Services, Health Care Financing Administration, Report to Congress, <i>Medicaid and Institutions for Mental Diseases</i> (Dec. 1992) ..... | 4    |
| Ga. Op. Att'y Gen. No. U70-183 (1970) .....   | 8    |
| Journal of the [Georgia] House (June 30, 1919)....  | 2    |
| SJ. Res. 44, 1918 Ga. Gen. Assembly Ann. Sess., 1918 Ga. Laws 921 .....   | 2    |
| B.K. Hill, et al., <i>The Quality of Life of Mentally Retarded People in Residential Care</i> , Social Work, 29(3) (1984) .....   | 9    |
| <i>The Hisssom Outcomes Study: A Report on Six Years of Movement into Supported Living</i> (Conroy, 1995) .....   | 9    |

BRIEF FOR RESPONDENTS

ADDITIONAL STATUTORY AND REGULATORY PROVISIONS

In the appendix to this brief, we set forth Section 2 of the Americans with Disabilities Act, 42 USC § 12101; and the full text of 28 CFR § 35.130.

COUNTER-STATEMENT OF THE CASE

I. The History of Institutionalization of Persons With Mental Disability.

Petitioners, without reference to anything in the record, depict the nation's, and Georgia's, history of institutionalization of persons with mental disability as a benevolent effort to provide the best treatment. But the historical record is in fact quite different, as a report upon which Congress relied in drafting the ADA recounts.

The report, U.S. Commission on Civil Rights, *Accommodating the Spectrum of Individual Abilities* (1983), explains that while in the 1850's reformers like Dorothea Dix had urged the creation of more institutional services for those who truly needed them, by the turn of the Century a more insidious phenomenon was underway: a movement to institutionalize a much larger population of persons with mental disabilities, so that society would not have them in its midst:

The Social Darwinism of the late 19th century spawned a eugenics movement, which peaked in the United States in the 1920s. This movement was based on the notion that mental and physical disabilities were the underlying source of nearly all social problems and were occurring with ever-increasing frequency due to reproduction of unfit persons. . . .

By the end of the 1920s, scientists had discredited many of the underpinnings of eugenics . . . . This undercut the primary rationale for segregating handicapped people from the rest of society, but the large

State residential institutions had established a momentum of their own. [*Id.* at 19-20].

See also, *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 454 (1985) (concurring opinion of Justice Stevens, joined by Chief Justice Burger); *id.* at 461-64 (opinion of Justice Marshall, joined by Justices Brennan and Blackmun, concurring in part and dissenting in part).

Georgia was in the mainstream of the eugenics movement. In 1918, the state legislature adopted a resolution establishing a "commission on the feeble-minded" to make recommendations "to relieve the State of the menace of the uncared-for feeble-minded who are such a fertile source of crime, poverty, prostitution and misery not only to themselves, but to all with whom they are brought into contact." S.J. Res. 44, 1918 Ga. Gen. Assembly Ann. Sess., 1918 Ga. Laws 921. The commission's ensuing report lamented that these "anti-social groups" were "allowed to propagate their kind" and to "leave behind them a large progeny of Feeble-minded," and recommended the "segregation" of these persons "into a state institution." Journal of the [Georgia] House, June 30, 1919, at 205, 206, 208, 261-62. A law so providing was promptly enacted. 1919 Ga. Laws 377.

From 1937 to 1970, Georgia law authorized the superintendents of such institutions to "submit to the State Board of Eugenics a recommendation that a surgical operation be performed . . . for the prevention of parenthood" on inmates "likely . . . to procreate a child." 1937 Ga. Laws 414. Since 1970, Georgia law conditions sterilization of institutionalized mentally retarded persons upon consent. 1970 Ga. Laws 683, § 3.

Expansion of institutional facilities for persons with mental disabilities continued unabated in Georgia until the early 1980's. This was long after most states had begun reducing their institutionalized populations by providing treatment in the community when appropriate.

## II. The National Shift to Community-Based Services, and Georgia's Resistance.

In the past three decades, societal attitudes nationally have changed. Congress has been on record since 1975 as favoring a shift to community-based care wherever appropriate. *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19-20 (1981). In 1981, a few months after this Court's decision in *Pennhurst*, Congress created the Home and Community Based Services Waiver Program, providing Medicaid reimbursement to States for the provision of community-based services to individuals with mental retardation or other related conditions who would otherwise require institutional care, upon a showing that the average cost of such services is not more than the cost of institutional services.<sup>1</sup> In 1986, Congress further expanded the waiver program to include certain community-based services for individuals with chronic mental illness as well.<sup>2</sup> In the case of mental illness (as distinguished from mental retardation), Medicaid reimbursement is available *only* when services are provided in the community.<sup>3</sup>

<sup>1</sup> Pub. L. No. 97-35, § 2176, 95 Stat. 357, 812-813 (1981), codified as amended at 42 USC 1396n(c). The program is called a "waiver" program, because it authorizes the Secretary of HHS to waive certain Medicaid requirements to enable states to target services to a particular population. For example, ordinarily a Medicaid service that is covered by a state must be available in the same amount, duration, and scope to all "categorically needy" Medicaid recipients and all individuals within a covered group of "medically needy" recipients. 42 USC 1396a(a)(10)(B); 42 CFR 440.240(b). By obtaining a waiver of this requirement, states can configure their services so that they go only to persons who would otherwise need institutionalization, without having to provide them to persons who would not. 42 USC 1396n(c)(3).

<sup>2</sup> Pub. L. No. 99-509, § 9411, 100 Stat. 1874, 2061-62 (1986).

<sup>3</sup> Medicaid generally excludes coverage for institutional care for individuals with mental illness except for individuals 65 and older and children under 21. 42 USC 1396d(a)(27)(B), 1396d(a)(14), (16). In 1992, the Department of Health and Human Services concluded in a report to Congress that this exclusion should remain in



Accordingly, Georgia was eligible to receive federal reimbursement for nearly two-thirds of the cost of treating the mentally retarded whether in institutions or community-based settings, and nearly two-thirds of the cost of providing certain services for the mentally ill but only if provided in community-based settings. In the words of an annual report of the Georgia Department of Human Resources (hereinafter "DHR"), which petitioner Olmstead administers, "Medicaid stretches state dollars, for every \$1 of state funds, Medicaid pays almost \$2 toward the cost of services." (JA 181; see also, JA 189-90).

In light of these federal incentives, most states began rapidly restructuring their programs for treating the mentally disabled to enable substantial portions of the previously institutionalized population to receive treatment in the community.<sup>4</sup> Georgia, however, lagged far behind.

Georgia did not seek Medicaid waivers for community-based services until 1989, when, under pressure from an earlier lawsuit (*SH and PF v. Edwards*, 886 F.2d 292 (11th Cir. 1989); see also JA 170), Georgia first applied for Medicaid reimbursement in order to provide the plaintiffs in that suit with community placement. There followed a number of signs suggesting that Georgia might now be ready to move more broadly toward community-based services. In 1992, Georgia applied for and ob-

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effect, as Medicaid funding is available to support community-based services, and these services are generally more cost-effective than institutional services. United States Department of Health and Human Services, Health Care Financing Administration, Report to Congress, *Medicaid and Institutions for Mental Diseases* (Dec. 1992). The report concluded that "cost-effectiveness research suggests that . . . inpatient care is used more frequently than it need be or should be." *Id.* at V-11.

<sup>4</sup> The dimensions of this phenomenon nationwide are suggested by data in briefs *amici curiae* for National Conference of State Legislatures ["NCSL"] *et al.*, supporting Petitioners, at 2-3, and for American Ass'n on Mental Retardation, *et al.*, Supporting Respondents.

tained advance authorization for Medicaid reimbursement to move another 1,000 persons out of institutions over a five-year period, 1992-97, at the rate of 200 per year. (JA 165; R79, Exh. 11). In 1993, the Georgia legislature amended its laws to allow state funds appropriated for mental disability programs to be transferred from institutional to community services. O.C.G.A. § 37-2-5.1(C)(3). The law also restructured the state service delivery system and gave it authority to contract with private providers of such services in the community. O.C.G.A. § 37-2-5.2 (A)(5).<sup>5</sup>

However, the promised movement did not materialize. By 1996, four years after it obtained the Medicaid authorizations, Georgia had moved only 147 of the promised 1,000 into the community. JA 165-66. When HCFA completed its audit of Georgia's compliance with the five-year undertaking in 1997, it found that Georgia had moved only 237 of the promised 1,000. (R79, Exh. 11). Meanwhile, Georgia had identified 523 institutionalized persons who could appropriately be treated in the community, but who remained in institutions. (JA 166; R105, Exh. 8, pp. 1-2). At the time this suit was filed, Georgia ranked 48th among the states in funding services for mental retardation in the community (JA 170-171).

### III. The Respondents.

A. L.C. is age 31. She is mildly mentally retarded and has also been diagnosed with schizophrenia. She is a friendly person who loves to draw and write. (JA 12,

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<sup>5</sup> With regard to persons with mental retardation who need a supervised environment, states contract with private entrepreneurs to establish community-based residential services supervised by on-site professionals. These private contractors rent or purchase residences, equip them, and charge a fixed fee per patient for treating those transferred to them. Residents pay their own room and board (usually out of their monthly federal SSI payments). The fixed fee covers personnel and treatment services. (JA 160-64).

46-48). She has lived more than half her life since age 14 in Georgia state institutions. (JA 12, 48, 49).

When she filed her complaint in May, 1995, L.C. had been confined for three consecutive years in a locked state psychiatric hospital (Georgia Regional Hospital, hereinafter "GRH-A") with more than 60 other persons, most of whom were in acute crisis. (JA 34, 49, 78, 90).<sup>6</sup> Most patients stay only a short time in this unit, until their acute symptoms of psychotic illnesses have been stabilized. (JA 90).

Although L.C. was hospitalized because of a mental illness (JA 14, 51), her psychiatric symptoms had been stabilized by 1993, and from that time forward the hospital's professional staff recognized that L.C. could appropriately be served in a community residential setting; this was conceded by petitioners. (JA 5, 32, 35, 36, 43, 46, 89, 91, 120, 205; Pet. Cert. App. 18a, 21a, 36a).

L.C.'s prolonged stay in the acute psychiatric unit was detrimental to her habilitation, as the professional staff recognized, and unnecessarily deprived her of the opportunity to participate in the social life of the community outside the locked doors of the institution. (JA 30, 31, 94, 97, 98, 204). Yet when the state's social worker urged the provision of treatment to L.C. in a community-based residential setting, his pleas were stonewalled by ignorance and outright resistance from the hospital administration. (JA 33, 39-41, 92, R59, SMF 161 & Exh. 29). Although appropriate community mental retardation services existed, the institutional staff had virtually no knowledge of these programs. (R59, SMF 42, 63, 66, 68, 69, 71; JA

<sup>6</sup> References to JA 88-93 in this brief are to the plaintiffs' statement of material facts (R59) filed with their motion for summary judgment. Other facts from that statement, not reprinted in the Joint Appendix, are cited herein as R59, SMF—. With one exception, identified when it occurs, all references cited are to facts which petitioners did not dispute in their response (R64).

205). Cost was never proffered as a reason for delaying L.C.'s placement in the community.

A few days after this suit was filed, L.C. was placed on a "trial visit" with her mother, who had a long history of inability to provide appropriate care for her. (R59, SMF 85-91, 113-14). The trial failed. L.C. was placed in another institution. (R59, SMF 117, 118, 124).

Despite the failed "visit," it was still the view of L.C.'s staff psychiatrist that she did not need institutionalization, and could be served in an appropriately supervised community-based placement. (JA 75, 90, 206). Finally, in February, 1996, nine months after suit was filed, L.C. was placed in a community-based program for people with mental retardation. (R59, SMF 134-135).

B. E.W. is mildly mentally retarded with an additional diagnosis of a personality disorder. (JA 63, 79). She had been confined in the same locked psychiatric ward as L.C. for more than a year when her request to intervene in this case was granted. (R11, R27; R59, SMF 7; JA 62, 78). The professional hospital staff knew that E.W. did not need to be institutionalized to receive appropriate treatment (JA 88, 89; R59, SMF 50; Pet. Cert. App. 18a, 21a, 22a-23a, 36a). In the fall of 1995, the staff psychologist noted that she needed another environment to "climb out of her depression," as the institution was not a "long-term growth environment" and the community was the appropriate setting for E.W. to receive habilitation. (JA 101, 213-214). E.W.'s treating psychiatrist likewise concluded that community services were appropriate for her (JA 210-212). Petitioners have conceded that E.W. could appropriately be served in a community program (JA 118-120).<sup>7</sup> Her unnecessary institutionalization was pro-

<sup>7</sup> While E.W. waited, she had kidney surgery and recovered. Inpatient medical care was briefly necessary for this medical procedure, but her treating physician was adamant that institutionalization was not. (JA 125-126; Pet. Cert. App. 23a, n.8; Pet. Cert. App. 36a-37a, n.1).



foundly disturbing to her, and prevented the development of independent living skills (JA 99, 100, 214).

E.W.'s prolonged wait for appropriate services in a more integrated setting did not end until the district court ruled in this action; she was then transferred in July, 1997, to the same residential setting in which L.C. resided. (Pet. Cert. App. 2a, n.2). Both Plaintiffs have now been receiving disability services in community-based programs in regular neighborhoods, L.C. for three years and E.W. for nearly two years. Neither has experienced difficulties or the need for re-institutionalization, and each, according to her home provider, is "progressing steadily." (R105, Exh. 2).

#### IV. The Relative Access to the Community at Large of Those Who Are Institutionalized and Those Who Receive Services in the Community.

L.C. and E.W. were hospitalized "voluntarily" in a locked facility (JA 62, 78). This did not mean, however, that they were free to leave the institution. Under Georgia law, a voluntarily admitted patient who wishes to be released must file an application, and the State has 72 hours to decide whether to grant the application. (O.C.G.A. 37-3-22).<sup>8</sup> As a practical matter, respondents were unable to apply for release, as they needed the treatment the State was willing to proffer them only in an institutional setting. On at least four occasions, E.W. attempted to leave the premises but was forced by hospital authorities to return and her freedom was further restricted. (R59, SMF 24 (disputed); see excerpts from GRH-A records, R59, Exh. 5). Under Georgia law, a voluntary patient at a state hospital may be picked up and returned to the hospital by the hospital police if she leaves without permission. Ga. Op. Att'y Gen. No. U70-183 (1970); *Etheridge v.*

<sup>8</sup> The procedure in Georgia is identical to that described in *Wyatt v. Poundstone*, 892 F. Supp. 1410, 1421 n.65 (MD Ala 1995); and *McNamara v. Dukakis*, 1990 WL 235439, at \*4 (D. Mass. 1990).

*Charter Peachford Hosp.*, 436 S.E.2d 669 (Ga. App. 1993).

The institution in which L.C. and E.W. were confined was never intended for long-term habilitation. (JA 101). Patients at GRH-A have virtually no contact with nondisabled persons, except the hospital staff, and prolonged confinement in the institutional environment is likely to result in regression or the development of maladaptive behaviors. (R59, SMF 99; JA 30, 31, 94, 97-99, 204, 214).

The conditions at GRH-A are typical of large State mental institutions. As described in the report of the U.S. Commission on Civil Rights, *supra*:

Institutionalization almost by definition entails segregation and isolation. Not only is segregation of the sexes prevalent, but segregation from families, normal society and peer groups is also a product of institutionalization. Indeed, a desire to segregate handicapped people from the rest of society prompted the development of residential institutions. [*Accommodating the Spectrum, supra*, at 32-33].

By contrast, those placed in community-based supervised residences (such as "group homes") are able to participate in the life of the community. See, e.g., Brief *Amici Curiae* of National Mental Health Consumers Self-Help Clearinghouse, et al.; R111, Attachment E at 8; *The Hissom Outcomes Study: A Report on Six Years of Movement into Supported Living* (Conroy, 1995); B.K. Hill, et al., *The Quality of Life of Mentally Retarded People In Residential Care*, Social Work, 29(3), 275-81 (1984).

#### V. Cost Is Not the Reason Respondents Were Denied Services in the Community.

Although petitioners claim in their brief to this Court that cost is the explanation for their failure, despite the recommendations of the State's professionals, to provide services to respondents in the community, the record tells a different story. There was incompetence and lack of

knowledge on the part of the administrators and staff of the institution, who did not know that suitable group home opportunities existed in the community, and devoted little effort to researching what was there. (R59, SMF 42, 63, 65-66, 68-71). Top administrative officials at GRH-A, the institution in which respondents were housed, were reluctant to suffer a decline in the institution's population; as one administrator explained to staff professionals pressing for the release of respondent L.C., their mission was to "staff the beds." (R59, Exh. 29; see also, JA 33-40). State officials were reluctant to downsize institutions because of the impact on employees in the institutions whose jobs would be jeopardized if the patient population declined. A state commission on mental disabilities appointed by the Georgia legislature insisted on an "[a]ssurance that no permanent state or county employee, classified or unclassified, will lose his or her job or benefits as a result of organizational change." (R111, Attachment A, at 19-20. See also, JA 172).

The cost to Georgia of maintaining patients in GRH-A ranged from \$80,000 per year to \$180,000 per year (JA 93). The cost to Georgia when respondents were moved to a group home in the community, after this suit was filed, was only \$20,000 per year (JA 162, 164).

In contrast to petitioners' representations in this litigation, DHR, which petitioner Olmstead administers, has repeatedly declared in other venues that "We need to promote the downsizing [of institutions] for two reasons. . . . First is the cost of in-patient care and the overhead. The second reason is we find for most consumers that they do far better and are able to be more productive [in community settings]." (JA 174). DHR's 1997 2-year plan declares that mentally disabled persons are "too often . . . inappropriately housed in state hospitals. . . . Treatment and support to consumers with serious mental illness can best be accomplished in community settings." (R111, Attachment E at 5. See also *Id.* at 6, 8, 28; R111, At-

tachment D at 8). Other DHR publications state that "Rather than rely on costly 'one size fits all' institutional care . . . individualized community services . . . offer a better quality of life." (JA 173); the average cost of serving patients in institutions far exceeds the cost of a full range of services in the community (JA 171); "[i]t is possible with the same level of funding to serve a larger number of individuals in community-based programs than at Brook Run [one of the state's institutions for the mentally retarded]" (R105, Exh. 8, p. 1); "expansion of services or enhancement of existing programs is expected to be funded from cost savings as a result of budget re-directs and *use of more cost effective services options, such as the use of community services in lieu of more costly hospital services*" (R111, Exh. E, p. 28).<sup>9</sup> See also, *id.*, Exh. D, p. 8 ("reduce inpatient services in favor of less costly community services"); J.A. 193.

Petitioners argued below that the cost savings attendant upon moving services from institutions to the community can be realized only if institutional facilities are closed commensurate with the decline in population. (R85, Exh. B; see also R105, Exh. 9, pp. 2-3). Thus, they contended it was necessary to wait until enough persons were ready for transfer to community-based services to permit the closing of a hospital or hospital wing. But the record showed that the State had identified 523 mentally retarded persons in Georgia institutions who could appropriately be served in existing community programs (JA 166), a number that exceeded the combined capacity of several state institutions. (R59, Exh. 63, pp. 12-13).

#### VI. The Rulings Below.

The district court ruled that the State's insistence that services be provided to LC and EW only in an institution, despite petitioners' concession that they could appropriately be served in the community (Pet. Cert. App. 36a), violated the ADA. The court reasoned that "'segrega-

<sup>9</sup> Throughout this brief, all emphasis is supplied.



tion' of individuals with disabilities is a 'form of discrimination' that Congress intended to eliminate," and "the regulations promulgated by the Attorney General to implement Title II plainly prohibit unnecessary institutionalization," *id.* at 37a, citing 28 CFR § 35.130(d). The court rejected petitioners' proffered defense that serving respondents in the community would require a "fundamental alteration" of its program, noting that "there is no dispute that defendants already have existing programs providing community services to persons such as plaintiffs" and "it is also undisputed that defendants can provide services to plaintiffs in the community at considerably less cost than is required to maintain them in an institution." *Id.* at 38a-39a.

On appeal, the Eleventh Circuit affirmed the district court's interpretation of the ADA, but reversed for further consideration of petitioners' fundamental alteration defense. The court of appeals unanimously ruled that the unnecessary institutionalization of mentally disabled persons is a *prima facie* violation of the ADA. Specifically, the court found that the ADA defines "discrimination" to include "segregation" and "exclusion and isolation" of individuals with disabilities from the community, *id.* at 11a, and that unnecessary institutionalization violates § 35.130(d) of the Attorney General's regulations implementing the ADA, which requires that services be provided in the "most integrated setting appropriate to the needs" of the individual, *id.* at 9a-10a. The court noted that Congress dictated that the Attorney General adopt this regulation (which is identical to § 41.51(d) of the "coordination regulations" adopted under the Rehabilitation Act of 1973), by including in § 204 of the ADA, 42 USC § 12134, a command that the Attorney General adopt regulations "consistent with" the earlier coordination regulations, *id.* The court also noted that Congress itself included an identical "most integrated setting" requirement in Title III of the ADA, the title governing pri-

vately-owned public accommodations, *id.* at 9a-10a, n.5. The court found this duty "analogous to the reasonable accommodation mandate in the employment setting," *id.* at 14a, and noted that it had previously applied Title I's reasonable accommodation mandate to Title II, *id.* at 13a.

The court of appeals reversed the district court, however, with respect to its treatment of petitioners' claimed defense. The court held that the duty to provide services in the most integrated setting "is not absolute. . . . [T]he State need not provide these services if to do so would require a fundamental alteration of its programs", *id.* at 25a. The issue, the court said, was whether providing service to respondents in the community would entail "additional expenditures . . . so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides," *id.* at 29a. The district court had not expressly addressed petitioners' argument that "because of fixed overhead costs associated with providing institutional care, the State will be able to save money by moving patients from institutionalized care to community-based care only when it shuts down entire hospitals or hospital wings," *id.* at 28a-29a.

On remand, the district court rejected petitioners' contention that they should be relieved of the burden to move LC and EW if they could show that providing community services to *all* the institutionalized persons in Georgia who could appropriately be treated in the community would be so burdensome as to entail a fundamental alteration in the program. Petitioners conceded that they could not make that showing with respect to L.C. and E.W. alone, and the district court ruled accordingly that petitioners had failed to establish their defense. On February 26, 1999, petitioners filed a notice of appeal of this ruling to the Eleventh Circuit.

#### VII. Sharpening and Narrowing the Issue Presented.

Before proceeding to the argument, it is important to identify what is *not* presented by the record of this case

and the ruling below, for the briefs of Petitioners and its supporting *amici curiae* address issues broader than are presented here.

First, in this case the State's own professionals concluded that respondents could be treated more appropriately in community-based group homes. Accordingly, this case does not present the question of how courts should resolve a claim when the State professionals have concluded otherwise and a plaintiff challenges the conclusion as erroneous. The court below was quite careful to limit its holding in this respect. (Pet. Cert. App. 21a).

Thus, this case has nothing to do with the State's choice of setting based on its professionals' assessment of persons' mental condition, degree of dangerousness, or ability to care for themselves, as erroneously postulated in Petitioners' formulation of the question presented.<sup>10</sup>

Second, the opinion below is clear that the ADA imposes no obligation upon States to transfer to community placements persons whose needs make such placement inappropriate. (Pet. Cert. App. 21a).

Third, the ADA does not compel any individual to accept a placement in a more integrated setting if he or she prefers to remain in an institutional setting offered by the State. 28 CFR § 35.130(e).

Fourth, nobody in this case contends, and the court below did not hold, that States are required to provide services. The only issue is whether a State that offers a service may insist that, as a price of receiving it, disabled persons must be unnecessarily segregated and isolated from the community.

<sup>10</sup> This Court has addressed the degree of deference owed the opinions of professionals employed by public entities in resolving issues under the Rehabilitation Act of 1973, *School Board of Nassau County v. Arline*, 480 U.S. 273, 287-88 (1987), and the deference owed a private professional sued as a defendant under the ADA, *Bragdon v. Abbott*, 118 S. Ct. 2196, 2209-13 (1998).

Finally, as it comes to this Court the case presents no question respecting the nature of the defense available to a public entity to resist providing services in the most integrated setting appropriate. The court below held that the State enjoys such a defense, and, indeed, reversed and remanded for the State to be afforded an opportunity to present that defense. Petitioners did not ask this Court to review the court of appeals' formulation of the defense, and will pursue that issue in their appeal of the district court's ruling, noticed on February 26, 1999.

#### INTRODUCTION AND SUMMARY OF ARGUMENT

Respondents, because of their disability, require services they are too poor to afford. The State of Georgia operates a unified program, providing those services in both mental institutions and community-based settings. The State's professionals concluded that respondents could appropriately be provided those services in a community setting, where they would have greater interaction with society at large. Nonetheless, the State's administrators refused to provide the services to respondents unless they remained segregated from the community in the locked ward of a mental institution.

The issue presented is whether this showing states a *prima facie* case of discrimination by reason of disability violative of the ADA (i.e., a violation unless the State sustains a defense that providing the services in a community setting would be so burdensome as to require a fundamental alteration in its services.) Petitioners insist that requiring respondents to remain in the institution to receive the services does not violate the ADA, even if furnishing those services in the community would impose no burden on the State. This follows, petitioners argue, because the ADA requires only that public entities afford persons with disabilities access to services *that are also provided to the nondisabled*.



As we show in this brief, petitioners have a mistakenly crabbed conception of the ADA. Title II of the ADA requires that public entities provide all of their services, including those earmarked solely for individuals with disabilities, in the most integrated setting appropriate to the needs of those individuals. The ADA requires this, so that individuals with disabilities can be integrated into the mainstream of society and not unnecessarily be deprived of the opportunity to participate in *all the other* services, programs and activities in which the nondisabled *do* participate.

The Attorney General, charged by Congress with responsibility for implementing Title II of the ADA, has so interpreted it. So have both courts of appeals to consider the question. Pet. Cert. App. 1a-30a; *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995), *cert. denied*, 516 U.S. 813 (1995).

In Part I, we deploy the customary tools of statutory construction to show that the ADA's requirement that services be provided in the "most integrated setting" applies to all such services, not just those furnished to the nondisabled. We show that provisions of the ADA, ignored in Petitioners' brief, make plain that public entities may not impose unnecessary segregation as the price for receiving disability services; and that the legislative history confirms that Congress fully intended that result.

Part II addresses a series of arguments advanced by Petitioners to suggest that Congress *could not have meant* to impose the obligation that so plainly appears in the text. Of principal importance, we show that petitioners' argument based on § 504 rests on faulty premises. The United States consistently argued that § 504 bans unnecessary institutionalization, the case law on that issue at the time the ADA was enacted was divided, and the ADA contains three important differences from § 504 that were chosen by Congress to assure that narrow interpretations of § 504's sweep could not be transported to the ADA.

## ARGUMENT

### I. APPLYING THE CUSTOMARY TOOLS OF STATUTORY CONSTRUCTION, THE ADA BANS ADMINISTRATION OF SERVICES, PROGRAMS, AND ACTIVITIES IN UNNECESSARILY SEGREGATIVE SETTINGS.

Petitioners' brief ignores critical language in the ADA that dictates the proper resolution of this case. That language illuminates the meaning of both "discrimination" and "by reason of . . . disability," and reveals that they have a quite different meaning than petitioners proffer. And, the legislative history confirms that Congress intended what the text of the ADA says, i.e., to ban public entities from requiring unnecessary segregation from the community as the price for receiving needed disability services.

#### A. The Text.

##### (1) "*Discrimination. . .*"

Section 202 of the Act, 42 U.S.C. § 12132, provides:

Subject to the provisions of this subchapter, no qualified individual with a disability shall, *by reason of such disability*, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or *be subjected to discrimination by such entity*.

The first part of § 202 forbids the exclusion of the disabled, by reason of their disability, from services, programs and activities available to the nondisabled. What, then, does the second part, italicized above, mean? Petitioners contend that "discrimination" means the "uneven treatment of similarly situated individuals." (Pet. Br. 21). That construction ignores other language that Congress placed in the statute to make clear that it intended a more sweeping conception of what constitutes discrimination against individuals with disabilities.

§ 2 of the ADA, 42 USC § 12101, includes several congressional findings. Their purpose, as explained by Senator

Harkin, the ADA's sponsor and floor manager in the Senate, was to "ensure once and for all that no Federal agency or judge will ever misconstrue *the congressional mandate to integrate people with disabilities into the mainstream.*"<sup>11</sup> The Findings state explicitly the meaning Congress accorded the term "discrimination:"

(2) *Historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;*

(3) *Discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization;*

\* \* \* \*

(5) *Individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, . . . failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, [and] segregation . . . [§ 2(a)(2), (3), (5)].*

Lest there be any doubt that the ban on discrimination in Title II prohibits the provision of disability services in unnecessarily segregative settings, Congress did not rest with the general command in § 202. In § 204, 42 USC § 12134—a critical section, which Petitioners ignore—Congress directed the Attorney General to "promulgate regulations . . . that implement" Title II, § 204(a), and cited specific Rehabilitation Act regulations that should be included in the ADA regulations:

(b) Relationship to other regulations. Except for "program accessibility, existing facilities", and "communications", regulations under subsection (a) of this section *shall be consistent with this Act and the coordination regulations under part 41 of title 28, Code of Federal Regulations . . . applicable to*

<sup>11</sup> 135 Cong. Rec. S4986 (daily ed. May 9, 1989).

recipients of Federal financial assistance under section 504 of the Rehabilitation Act of 1973. . . . [§ 204(b)].

§ 204 left no discretion in the Attorney General to omit any of the cited Rehabilitation Act coordination regulations. The ADA regulations "*shall be consistent with . . . the coordination regulations.*" Congress insisted upon this, because the "first purpose" of Title II of the ADA was:

*to make applicable the prohibition against discrimination on the basis of disability, currently set out in regulations implementing Section 504 of the Rehabilitation Act of 1973, to all programs, activities, and services provided or made available by state and local governments or instrumentalities or agencies thereto . . .*<sup>12</sup>

§ 204 "incorporated by reference" the Rehabilitation Act's coordination regulations,<sup>13</sup> so that those regulations would "apply as well" to the ADA.<sup>14</sup>

The § 504 coordination regulations cited in § 204 included the following provision:

<sup>12</sup> S. Rep. No. 101-116, 101st Cong., 1st Sess. (1989) (hereinafter "S. Rep.") at 44; H.R. Rep. No. 101-485, Part 2, 101st Cong., 2d Sess. (1990) (hereinafter "H. Rep. II"), at 84. See also, *id.*, Part 3 (hereinafter "H. Rep. III"), at 49-50.

<sup>13</sup> H. Rep. III, at 51.

<sup>14</sup> H. Rep. II, at 84. The text of § 204 also instructs the Attorney General to make the regulations "consistent with" the ADA, which the reports explain is a reference to incorporating the concepts articulated in Titles I and III of the ADA. S. Rep., at 44; H. Rep. II, at 84; H. Rep. III, at 51. The reports are explicit, however, that to the extent the § 504 regulations provide greater protections to persons with disabilities than the other titles of the ADA, those regulations are to be incorporated into the Title II regulations. "[N]othing in the other titles [of the ADA] should be construed to lessen the standards in the Rehabilitation Act regulations which are incorporated by reference in Section 204." H. Rep. III, at 51. "[T]he requirements of those regulations apply as well, including any requirements . . . that go beyond Title I and III." H. Rep. II, at 84.



Recipients [of federal funds] shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons. [28 CFR § 41.51(d)].

In obedience to § 204 of the ADA, the Attorney General adopted the following provision in the ADA regulations:

A public entity shall administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. [28 CFR § 35.130(d)].<sup>15</sup>

§ 35.130(d) controls this case. It is as binding as if it appeared on the face of the statute, for Congress commanded its inclusion, indeed "incorporated [it] by reference." *United States v. Board of Comm'rs of Sheffield, Alabama*, 435 U.S. 110, 134 (1978).

Petitioners, who never acknowledge § 204, attempt to dismiss the regulation as a frolic of the Attorney General. See, e.g., Pet. Br. 6: "Nor can plaintiffs sidestep this conclusion by relying on an executive-branch regulation promulgated by the Department of Justice." But Congress in § 204 explicitly embraced the designated provisions of the § 504 regulations, choosing carefully from among the two dozen sets of regulations that had been issued by a variety of federal agencies to implement Section 504,<sup>16</sup> selecting one set of regulations for some issues and another for other issues.<sup>17</sup>

<sup>15</sup> The only changes from the text of the parallel 504 regulation were changes to conform to the different wording of the ADA, which applies to all public entities and not merely those receiving federal funds; uses "services, programs and activities" in lieu of 504's "programs and activities;" and uses "individuals with disabilities" in lieu of 504's "handicapped persons."

<sup>16</sup> The numerous sets of Rehabilitation Act regulations are cited in *Alexander v. Choate*, 469 U.S. 287, 297 n.17 (1985).

<sup>17</sup> See also, § 204(c), directing the Attorney General to pattern the ADA regulations respecting "facilities and vehicles covered by

Thus, the "plain language" that guides the resolution of this case is not only the broad term "discrimination," but the meanings of that term articulated in § 2 of the ADA ("isolate and segregate", "institutionalization"), and the "most integrated setting" requirement of § 35.130(d). We turn, now, to an examination of that regulation.

Although Petitioners argue that the ADA's ban on "discrimination" applies only to services, programs and activities in which the nondisabled participate, no such limitation appears in § 35.130(d). That section applies, by its terms, to all "services, programs, and activities." There is not a whisper that it is limited to only the subset of services, programs and activities enjoyed by the nondisabled. The universality of its application is consistent with Congress' declared intention to make applicable the 504 coordination regulations "to all programs, activities, and services provided or made available by state and local governments." See p. 19, *supra*, text at n.12.

§ 35.130(d) does not refer to "most integrated services, programs, and activities." Rather, it directs that "services, programs, and activities" be provided "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The focus of this provision, by its plain language, is not on whether the service is integrated, but on whether the setting in which the service is provided is integrated. As the Attorney General explained in the section-by-section analysis that accompanied issuance of the Title II regulations, an "integrated setting" within the meaning of § 35.130(d) is "a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . ."

[Title II]" after yet a third source—"the minimum guidelines and requirements issued by the Architectural and Transportation Barriers Compliance Board." Title III of the ADA (privately-operated public accommodations) includes a "most integrated setting" command virtually identical to that which the Attorney General included in the regulations implementing Title II. See ADA, § 302(b)(1)(B).

56 Fed. Reg. 35705 (July 26, 1991). Petitioners do not dispute that furnishing the services Respondents need in a community-based group residence permits them greater interaction with nondisabled persons than furnishing those services in the locked ward of a mental institution. (Pet. Cert. App. 8a).

Confirmation that § 35.130(d) is not limited to "integrated services . . ." is provided by the structure of § 35.130 as a whole. That section enumerates all of the "prohibitions against discrimination" effected by Title II of the ADA. § 35.130(a) repeats the general prohibitory language of § 202 of the ADA. § 35.130(b) affords qualified individuals with disabilities the maximum possible access to services, programs and activities in which the nondisabled participate.<sup>18</sup> § 35.130(c) declares that the ADA does not forbid public entities from providing services that are earmarked exclusively for persons with disabilities. Having thus discussed the two categories of services—those in which the nondisabled participate [130(b)] and those which are disability-only [130(c)]—130(d) then states unqualifiedly that services are to be administered in the "most integrated setting appropriate to the individual."

Unlike 130(b), there is nothing in 130(d) that suggests it is limited to services in which the nondisabled participate. Nor is there any other justification for reading (d) to apply to the services discussed in (b), but not those discussed in (c) which immediately precedes it.

(2) *"... By Reason of Disability."*

Petitioners contend that even if respondents are suffering "discrimination" within the meaning of § 202, it is not

<sup>18</sup> Most of the subsections in § 35.130(b) expressly mention that the services referenced are provided to, afforded to, or enjoyed by "others," i.e. persons without disabilities. See § 35.130(b)(ii), (iii), (iv), (vii). These words do not appear in (v) and (vi) because it is obvious from the text of these provisions that the services and programs referenced are enjoyed by non-disabled persons.

"by reason of [their] disability." This follows, petitioners say, because their failure to provide services in the most integrated setting appropriate was motivated by factors unconnected to respondents' mental disabilities.

The ADA reaches practices that have the effect of discriminating against individuals with disabilities, not just acts intended to do so.<sup>19</sup> Petitioners acknowledge that this is so as to Titles I and III, but assert that Congress was less ambitious in enacting Title II. (Pet. Br. 29). Again, petitioners overlook § 204, which incorporates by reference the § 504 regulations banning conduct with discriminatory effects and also states that the ADA regulations shall be "consistent with this Act." The Committee reports made clear that the latter directive was intended to incorporate into Title II the types of discrimination articulated in Titles I and III. See n.14, *supra*.

By directing the Attorney General to adopt "the most integrated setting" regulation, Congress indicated that the statutory language "by reason of disability" applied to a state's providing disability-only services in a needlessly segregated setting. Indeed, the statute's primary focus on ending the isolation of the disabled and integrating them into the mainstream of American life, commands that approach.

Respondents were deprived of access to the community because the State conditioned the provision of services

<sup>19</sup> This Court assumed that that was the correct construction of § 504, in *Alexander v. Choate*, *supra*, 469 U.S. at 292-97, noting that the lower courts and federal agencies uniformly had so held, *id.* at 297 n.17. So did the Rehabilitation Act coordination regulations that Congress directed the Attorney General to adopt for Title II, 28 CFR, Part 41. The specific enumeration of acts of discrimination in Titles I and III of the ADA include many practices that are innocently motivated. Congress directed the Attorney General to include the prohibitions of Titles I and III in the Title II regulations. (See note 14, *supra*). The congressional reports on the ADA expressly declare that Congress intends the ADA to ban conduct with discriminatory effects. S. Rep., at 6; H. Rep. II, at 29; H. Rep. III, at 26.



they needed on their living in an institution. It was "by reason of their disability"—their need for those services—that they were thus isolated. Other services, that the state provides to the nondisabled, do not carry as a condition that the recipients agree to unnecessary institutionalization. The State thus discriminates between the disabled and nondisabled, by effectively segregating some with disabilities from access to the community. When that segregation is not necessary for the provision of appropriate treatment, it is discriminatory. Can there be any doubt that AIDS patients would be suffering discrimination "by reason of [their] disability" if a state, without medical or public health justification, conditioned the provision of medical services for AIDS upon their agreeing to live in a locked ward?

Petitioners' contention—that segregation is not "by reason of disability"—would make sense if a disabled person were convicted of a crime and incarcerated in a prison. It would then be correct to say that that person's exclusion from the community is not "by reason of disability" (it is by reason of committing a crime). But disability—and the corresponding need to secure treatment therefor—is the *only* reason that respondents were segregated from the community.<sup>20</sup>

<sup>20</sup> Respondents' institutionalization was "by reason of disability" for a second reason. Petitioners' asserted non-disability-related justification for not providing services to respondents in the community is that the State would incur additional expense, still having to bear the fixed costs of operating the institution while also paying the community-based provider. See p. 13, *supra*. Petitioners did not prove that this was their justification, or even that the claim of additional expense is true. But even if they had, those institutional costs existed only because the State had earlier pursued a policy of institutionalizing disabled persons who did not need to be there, during an era in which isolating the mentally disabled from the community was official policy, and in consequence finds itself with more institutional facilities than are necessary to treat those who truly need institutionalization. The alleged transitional "cost" of moving services into the community thus is the product of an earlier history of antipathy for the disabled.

## B. The Legislative History.

The legislative history of the ADA provides further proof that Congress intended the "most integrated setting" regulation to forbid the provision of disability-only services in unnecessarily segregative settings.

### (1) *The Hearings.*

Sen. Lowell Weicker had been the principal sponsor of the ADA when it was introduced in 1988, but was defeated for reelection that November. He testified as a witness at the Senate hearings in early 1989. His account of the problems that would be solved by enactment of the ADA included the following:

For years, this country has maintained a public policy of protectionism toward people with disabilities. We have created monoliths of isolated care in institutions and segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal. It was not for blacks; it is not for the disabled.<sup>21</sup>

Attorney General Dick Thornburgh, testifying on behalf of President Bush, decried the "intolerable life of isolation" suffered by many individuals with disabilities,<sup>22</sup> who are "still too often shut out of the economic and social mainstream of American life" and who deserve "full participation in and access to all aspects of society."<sup>23</sup>

Many individuals testified about the brutal treatment and unnecessary isolation suffered by those in mental institutions.<sup>24</sup> This was echoed by the administrators of some state systems, who testified, *inter alia*:

<sup>21</sup> Americans with Disabilities Act, Hearing before the Senate Committee on Labor and Human Resources and the Sub-Committee on the Handicapped, 101st Congress, 1st Session, at 215 (1989).

<sup>22</sup> Quoted in S. Rep., at 9, and in H. Rep. III, at 32.

<sup>23</sup> Hearing before the Senate Committee, *supra* n.21, at 195.

<sup>24</sup> Oversight Hearing on H.R. 4498, Americans with Disabilities Act of 1988: Hearings Before the Subcomm. On Select Educ. Of

People with mental disorders have been herded into jail-like asylums . . . . Mental patients have been isolated, chained and beaten, and abused . . . . Our clients face exclusion from jobs, housing, and the basic rights citizens enjoy.<sup>25</sup>

\* \* \* \*

But we—and now I am speaking as a person with a life-long disability—have never been recognized as full citizens. We have had to endure segregation in much the same way people of color and women have endured discrimination and segregation until recently, and, sadly, even today. *But the segregation and stigmatization of people with certain disabilities has been even greater. For people with disabilities such as mental retardation, cerebral palsy, mental illness . . . we have been institutionalized. . . .* In protesting the right not to be segregated we also encourage the opportunity for integration and learning.<sup>26</sup>

\* \* \* \*

The next powerful movement is the rising up of people with mental retardation locked up in institutions. . . . The Americans with Disabilities Act will provide . . . an opportunity to reach the most segregated members of our society.<sup>27</sup>

the House Comm. on Educ. and Labor, 100th Cong., 2d Sess. (1988) (hereinafter, *Oversight Hearing*), at 27-38, 173-75, 229-34; Staff of House Comm. on Educ. and Labor, 101st Cong., 2d Sess., Report on P.L. 101-336, Legislative History of the Americans with Disabilities Act, (Comm. Print 1990) (hereinafter "*Leg. Hist.*"), at 1080-81, 1230-35, 1513-17.

<sup>25</sup> *Leg. Hist.*, at 1161-62 (statement of Marilyn Levin, on behalf of Edward M. Murphy, Commissioner, Massachusetts Department of Mental Health).

<sup>26</sup> *Id.*, at 1725-27 (statement of Deanna Durrett for Josef Reum, Commissioner, Indiana Department of Mental Health).

<sup>27</sup> *Oversight Hearing*, supra, at 65-66 (statement of Ed Preneta, Director, Connecticut Developmental Disabilities Office).

## (2) The Committee Reports.

The Senate Report, and the four reports in the House, all confirm that Congress' intent was to go beyond simply mandating equal treatment for individuals with disabilities, and to break down barriers that unnecessarily prevented them from participating fully in society. The declared "purpose of the ADA" was to provide a:

comprehensive national mandate to end discrimination against individuals with disabilities and to bring persons with disabilities into the economic and social mainstream of American life. . . .<sup>28</sup>

The reports note that studies by federal agencies all "reach the same fundamental conclusions," the first of which is stated as follows:

Historically, individuals with disabilities have been isolated and subject to discrimination and such isolation and discrimination is still pervasive in our society.<sup>29</sup>

The reports describe "segregation" as a form of discrimination prohibited by the ADA, and make clear that this is an evil distinct from the exclusion of individuals from programs in which the nondisabled participate. The Senate Report states:

One of the most debilitating forms of discrimination is *segregation*. . . . Discrimination *also* includes *exclusion*, or denial of benefits, services, or other opportunities that are as effective and meaningful as those provided to others.<sup>30</sup>

House Report III states:

<sup>28</sup> S. Rep., at 2, 20; H. Rep. II, at 22, 50; H. Rep. III, at 23; *Id.*, Part 4, at 23 (hereinafter, "*H. Rep. IV*"). See also, *Id.*, Part 1, at 24 ("to welcome individuals with disabilities fully into the mainstream of American society") (hereinafter "*H. Rep. I*").

<sup>29</sup> S. Rep. at 6; H. Rep. II, at 28.

<sup>30</sup> S. Rep. at 6.



[A]s in the finding 35 years ago by the Supreme Court in *Brown v. Board of Education* . . . segregation for persons with disabilities "may affect their hearts and minds in a way unlikely ever to be undone."

\* \* \* \*

The ADA is a comprehensive piece of civil rights legislation which promises a new future of inclusion and integration, and the end of exclusion and segregation.

\* \* \* \*

Section 504 of the Rehabilitation Act served *not only* to open up public services and programs to people with disabilities but has *also been used to end segregation. The purpose of Title II is to continue to break down barriers to the integrated participation of people with disabilities in all aspects of community life.*<sup>31</sup>

The reports quote the following conclusions from the U.S. Commission on Civil Rights' report, *Accommodating the Spectrum*, *supra*:

Despite some improvements . . . [discrimination] persists in such critical areas as education, employment, *institutionalization*, medical treatment, involuntary sterilization, architectural barriers, and transportation.<sup>32</sup>

The Civil Rights Commission report, at p. 33, explained that "[i]nstitutionalization almost by definition entails segregation and isolation." A section of the Commission's Report recounted "Forms of Handicap Discrimination:"

<sup>31</sup> H. Rep. III, at 26, 49. See also, H. Rep. I at 25 (ADA is a civil rights bill, required because the nation cannot "afford to exclude, or segregate in any way, the significant number of its citizens who have disabilities."); H. Rep. II, at 40 ("the unfortunate truth is that individuals with disabilities are a discrete, specific minority who have been insulated in many respects from the general public . . . . This Act will finally set in place the necessary civil rights protections for people with disabilities.")

<sup>32</sup> S. Rep. at 8; H. Rep. II at 31 (brackets in Committee report).

Conduct, policies, and practices discriminate against handicapped people in several ways: intentional exclusion; unintentional exclusion; *segregation*; [et al.] . . . .

Segregation singles out handicapped people and separates them from the rest of society, frequently as a condition for receiving some service or benefit. . . . *Mental health and mental retardation institutions that house residents in almost complete isolation from the non-handicapped community are perhaps archetypal examples of segregation.* [Id. at 40-41].

The breadth of Congress' purpose in enacting the ADA is also attested by its explanation for requiring accessible transportation for the disabled. Congress did not justify this requirement on the ground that, as the nondisabled use transportation, the disabled are entitled to equal access. (That is the rationale one would expect if the statute were as narrow as Petitioners contend.) Rather, the reports stressed that access to transportation was required because it was crucial to Congress' larger goal of mainstreaming those with disabilities into the larger community:

Transportation is the linchpin which enables people with disabilities to be integrated and mainstreamed into society. [A]ccess to transportation is the key to opening up education, employment, recreation; and other provisions of the [ADA] are meaningless unless we put together an accessible transportation system in this country.<sup>33</sup>

Congress required public entities to provide "paratransit" systems for those unable to use public transportation, because this disability-only service was essential to achieving the ADA's overarching goal of mainstreaming persons with disabilities.<sup>34</sup>

<sup>33</sup> S. Rep. at 13. See also, H. Rep. II, at 37, 84; H. Rep. IV, at 25.

<sup>34</sup> S. Rep. at 13; H. Rep. I, at 24; H. Rep. II, at 38, 50-52.

### (3) *The Floor Debates.*

The floor debates contain further evidence that Congress fully intended what the words of the ADA say. Senator Harkin declared, when he introduced the bill, that one of the ADA's purposes is "*getting people . . . out of institutions. . .*"<sup>35</sup> During the floor debates, he explained that the ADA

guarantees individuals with disabilities the right to be integrated into the economic and social mainstream of society; segregation and isolation by others will no longer be tolerated.<sup>36</sup>

Senator Kennedy, a co-sponsor, and chair of the Senate committee that reported out the ADA, stated:

The Americans with Disabilities Act will end this American apartheid. It will roll back the unthinking and unacceptable practices by which disabled Americans today are segregated, excluded, and fenced off from fair participation in our society by mindless biased attitudes and senseless physical barriers.<sup>37</sup>

Congressman Miller, a co-sponsor in the House, stated:

[I]t has been our unwillingness to see all people with disabilities that has been the greatest barrier to full and meaningful equality. Society has made them invisible *by shutting them away in segregated facilities.*<sup>38</sup>

President Bush, in signing the ADA, stated that its purpose is to:

ensure that people with disabilities are given the basic guarantees . . . Independence, freedom of choice, control of their lives, the opportunity to blend

<sup>35</sup> 135 Cong. Rec. S4986 (daily ed. May 9, 1989).

<sup>36</sup> 135 Cong. Rec. S10713 (daily ed. Sept. 7, 1989).

<sup>37</sup> 135 Cong. Rec. S4993 (daily ed. May 9, 1989).

<sup>38</sup> 136 Cong. Rec. H2447 (daily ed. May 17, 1990).

fully and equally into the rich mosaic of the American mainstream.

\* \* \* \*

And [so] I sign legislation which takes a sledgehammer to another wall, one which has for too many generations separated Americans with disabilities from the freedom they could glimpse but not grasp. . . .<sup>39</sup>

### C. *The Lessons of the Text and Legislative History.*

As the text and legislative history make clear, Congress intended the ADA to strike at the whole range of problems that result from discrimination against individuals with disabilities and that have denied such individuals full participation in the economic and social life of this Nation. Petitioners acknowledge that the ADA requires them to make integrated services accessible to persons with disabilities. But, they contend, the ADA was not meant to address the most flagrant and pervasive of all engines of exclusion: the unnecessary segregation of some persons with mental disabilities, which prevents them from participating in *any* of those integrated services.

The statute that eventuates from this reasoning makes no sense: it is as if, during the era of slavery, Congress has enacted a law forbidding race discrimination in employment but leaving slavery in place. It would take a remarkably clear text to convince that Congress intended so illogical a dichotomy.

The reason Congress wanted those with disabilities to go to parks and museums side by side with the non-disabled, rather than merely in separate groups (Pet. Br. 41-42), was not that they would thus better appreciate the flowers and paintings, but because inclusion in the

<sup>39</sup> Reprinted in National Council on Disability, *Equality of Opportunity: The Making of the Americans with Disabilities Act* at App. G (1997).



"mainstream" was viewed by Congress as the entitlement of those with disabilities. *A fortiori*, Congress did not want persons with disabilities unnecessarily kept from attending parks and museums *altogether*, as petitioners have done here.

#### D. Petitioners' Contrary Account.

In the face of overwhelming evidence that Congress meant to impose upon public entities an obligation to administer disability-only services in the "most integrated setting" appropriate to individuals' needs, petitioners offer up, in support of a contrary interpretation, one smidgin of legislative history, and one passage in the Attorney General's section-by-section analysis of the ADA regulations. Neither supports petitioners' contentions.

##### (1) *The Chafee Bill.*

Petitioners contend that Congress' failure to adopt Senator Chafee's proposed amendments to the Medicaid law in 1990 reflects Congress' understanding that the ADA did not compel states to provide disability services in the community when institutionalization is an unnecessarily segregative setting. (Pet. Br. 32). This is a complete non-sequitur.

Congress had *already* amended the Medicaid law to permit states to secure Medicaid reimbursement for community-based treatment of mentally retarded and mentally ill persons who would otherwise be institutionalized. See p. 3, *supra*. By virtue of those amendments, Medicaid pays the same percentage of the state's costs of treatment of mental retardation, whether provided in an institution or in the community, and Medicaid *favors* provision of community-based treatment to persons with mental illness. See p. 3, *supra*. No new amendments thus were needed to enable states to secure Medicaid reimbursement for serving persons in community-based settings when appropriate, rather than in institutions, in obedience to the ADA's "most integrated setting" command.

Senator Chafee's bill <sup>40</sup> would have required the States to finance community-based services to all eligible Medicaid recipients who had developed an SSI-level disability (i.e., a disability that precluded working) before a certain age. The bill would have made these services mandatory Medicaid services, meaning that each state participating in the Medicaid program would have been required to provide such services to every Medicaid recipient who qualified for them—a much broader population than is protected by the "most integrated setting command" of the ADA, as it includes all those whose disabilities are not severe enough to qualify for institutionalization in the absence of community services.

Senator Chafee understood that the "ADA as it is currently drafted, will integrate fully those with disabilities into everyday American life."<sup>41</sup> He viewed his bill as a "logical partner" to the ADA <sup>42</sup> because it went beyond the ADA in three respects: (1) it would have mandated mental disability services, whereas the ADA is operative only if the states elect to provide these services; (2) it would have mandated these services for all qualifying Medicaid recipients meeting the SSI definition of disability, whereas the ADA integration mandate applies only to persons receiving services in unnecessarily segregated settings; and (3) its mandate was absolute, and not tempered by a fundamental alteration defense.

The respects in which the Chafee bill went beyond the ADA would have greatly increased the costs of mental disability services for both the federal and state governments. That Congress did not adopt this ambitious bill says nothing about the meaning of the ADA.

<sup>40</sup> The Chafee bill appears at 135 Cong. Rec. 1960-71 (Feb. 8, 1989).

<sup>41</sup> 135 Cong. Rec. 8519 (May 9, 1989).

<sup>42</sup> *Id.* at 8518.

(2) *The Attorney General's Section by Section Analysis.*

Petitioners point to a passage of the section-by-section analysis in which the Attorney General cites examples of how persons with disabilities must be afforded the opportunity to participate in programs together with non-disabled persons. This, they argue, shows that the "most integrated setting" command applies only to activities in which the nondisabled participate. (Pet. Br. 41-42).

It would be a sufficient answer that two examples of a provision's operation do not justify an "infer[ence] from . . . silence" that those exhaust the provision's meaning. *Thomas Jefferson University v. Shalala*, 512 U.S. 504, 516 (1994). But here there is a more compelling answer. The passage petitioners cite appears in the portion of the section-by-section analysis describing 130(b)(iv), and explains how 130(b)(iv) intersects with several other provisions, including 130(d). Not surprisingly, the examples used to show that intersection involved services in which the nondisabled participate, for it is to those services that 130(b)(iv) is addressed. See p. 22, *supra*. When the section-by-section analysis later arrives at its description of 130(d) *per se*, no examples are provided. Rather, the analysis states without qualification that services are to be provided in a setting that permits the maximum interaction with nondisabled persons consistent with the needs of the person with disabilities. See pp. 21-22, *supra*.

E. *The Attorney General's Consistent Interpretation of the ADA.*

The Attorney General, charged with primary responsibility for enforcing the ADA, has consistently interpreted the ADA to condemn unnecessary institutionalization when appropriate services can be provided in the community. [Indeed, as we show in Part II-A, *infra*, this was also the consistent Attorney General interpretation of

§ 504 of the Rehabilitation Act in the dozen years preceding enactment of the ADA. There is thus an unbroken line of Attorney General concurrence spanning four administrations and more than twenty years.]

Attorney General Thornburgh, who promulgated the implementing regulations following its passage, has confirmed his interpretation in an *amicus curiae* brief in this Court. His successor, the current Attorney General, has filed *amicus curiae* briefs in several cases, including in the court below, taking the same position.<sup>43</sup>

Surely, this conclusion is based on a "permissible construction of the statute," and as such is entitled to deference from the judicial branch. *Chevron v. NRDC, Inc.*, 467 U.S. 837, 843 (1984). An agency's interpretation of its own regulation merits "substantial deference." *Thomas Jefferson University v. Shalala*, 512 U.S. 504, 512 (1994); *Martin v. OSHA*, 499 U.S. 144, 150-51 (1991).<sup>44</sup> Congress, by directing the Attorney General to adopt regulations spelling out the forms of discrimination forbidden by Title II, signalled its preference that the primary task of interpretation be entrusted to the executive branch. "[F]ederal judges—who have no constituency—have a duty to respect legitimate policy choices made by those who do." *Chevron*, 467 U.S. at 866. That duty is easiest to perform when, as here, the administrative interpretation is so faithful to the statutory text and the announced legislative purpose.

Petitioners attempt to dismiss the Attorney General's interpretation as a "litigation position" unworthy of deference (Pet. Br. 42). But as this Court held in *Auer v. Robbins*, 117 S. Ct. 905, 912 (1997), an agency's inter-

<sup>43</sup> See e.g., *Helen L.*, *supra*, 46 F.3d at 327, 335.

<sup>44</sup> These principles apply to administrative interpretations impacting states. *U.S. v. Alaska*, 503 U.S. 569 (1992); *Rust v. Sullivan*, 500 U.S. 173 (1991).



pretation of its own regulation in a legal brief is entitled to deference, so long as it is not a post-hoc rationalization for past agency action under attack. Absent that incentive to justify past action, "there is simply no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment." *Id.*

#### F. Petitioners' Invocation of *Gregory v. Ashcroft*.

Petitioners assert that the interpretation of the Department of Justice and lower courts does not satisfy the "plain language" rule of *Gregory v. Ashcroft*, 501 U.S. 452 (1991). There is a serious question whether *Gregory* applies here, as we explain shortly, but the decisive point is that the interpretation here would satisfy the *Gregory* test even if applicable. The language of the ADA, and of the regulations it directed the Attorney General to adopt, clearly bans segregation, and requires that public entities administer their services in the most integrated setting appropriate to the needs of the individual. There are no exceptions, no equivocations.<sup>45</sup> Administrators of State mental health programs understand that "most integrated setting" means moving individuals with disabilities from mental institutions to community-based settings. See, Brief for Former Commissioners, et al., at n.3. See also, the NCSL Brief which attaches a statement of Kathryn Power, "the immediate Past President of State Mental Health Program Directors (ASMHPD), which represents all 50 states and 5 territorial state mental health agencies" (*id.* at 1a). Ms. Powers reports that there is

a growing consensus within the mental health field that, whenever feasible, people with mental illnesses should receive services in a community, rather than institutional, setting. The principle that services

<sup>45</sup> By contrast, the statute in *Gregory* contained an exception for policy-making officials, and it was the ambiguity of this exception (as applied to state judges) that posed the interpretive task in that case.

should be provided in the most integrated setting possible is supported by the values of those who administer our public mental health system. . . . [*Id.* at 2a].

To be sure, the ADA does not spell out *in haec verba* every application of the "most integrated setting" command, but as this Court noted in *Pennsylvania Department of corrections v. Yeskey*, 118 S. Ct. 1952, 1955-56 (1998), the ADA's breadth does not mean it is ambiguous. In *Yeskey*, the Court held that the ADA applies to state prisons, even if that application was "not expressly anticipated by Congress," *id.* at 1956. See also, *Sedima SPRL v. Imrex Co.*, 473 U.S. 479, 499 (1985). Here, there can be no doubt that Congress *did* contemplate the ADA's application to unnecessary institutionalization of persons with mental disabilities.

In any event, it is doubtful that *Gregory* applies here, a doubt this Court noted but did not resolve in *Yeskey*, 118 S. Ct. at 1954. Unlike *Gregory*, which involved a claimed congressional overriding of a state constitution on an issue at the core of the state's governance, this case involves a more mundane question: in which of two settings, both administered by the State, should respondents receive their services? Whatever the answer, it is unlikely to alter "the usual constitutional balance of federal and state powers," *Gregory*, 501 U.S. at 460, especially as the federal government is paying nearly two-thirds of the cost. See pp. 3-4, *supra*. The statute makes clear that States—indeed all public entities—are to be treated exactly the same as everyone else covered by the ADA.<sup>46</sup>

The extension of *Gregory* sought by petitioners would frustrate the application of all federal civil rights statutes to the States, even when, as here, Congress announces unequivocally that it intends States to be governed in

<sup>46</sup> See § 502 of the ADA, 42 USC § 12202.

exactly the same way as other parties. In particular, petitioners' approach would overrule significant decisions of this Court. For example, prior to 1991, there was no explicit statement in Title VII of the Civil Rights Act of 1964 that disparate impact was a form of prohibited discrimination. This Court concluded that it was, by applying typical tools of statutory construction in a case involving private parties, *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971), and then applied that interpretation in suits involving States without a second thought. *Dothard v. Rawlinson*, 433 U.S. 321 (1977); *Connecticut v. Teal*, 457 U.S. 440 (1982).

## II. PETITIONERS' ARGUMENTS—THAT CONGRESS COULD NOT HAVE INTENDED WHAT THE STATUTE PLAINLY SAYS—ARE UNPERSUASIVE.

We address, *seriatim*, a series of arguments advanced by Petitioners that are apparently designed to show that Congress did not mean what it said in the ADA. These arguments rest entirely on factual and analytical errors.

### A. "The Dog That Didn't Bark:" The Contention That the History of Implementation of Section 504 of the Rehabilitation Act Shows That Congress Did Not Intend the "Most Integrated Setting" Command of the ADA to Apply to Disability-Only Services.

Petitioners make the following assertions: (1) prior to the enactment of the ADA, neither the United States, in implementing § 504 of the Rehabilitation Act, nor the courts, in construing it, thought that it banned unnecessary institutionalization; (2) the language of Title II of the ADA is identical in all meaningful respects to the language of § 504; and (3) the ADA regulations are identical to those that were at issue in the pre-ADA § 504 cases. (Pet. Br. 22-30). It follows, petitioners argue, that Congress must have intended the ADA not to ban unnecessary institutionalization. (*Id.* at 22).

All three of petitioners' assumptions are wrong. In consequence, the conclusion is wrong as well.

### (1) *Petitioners' Account of the Enforcement of § 504 Is Wrong.*

Petitioners are simply wrong in thinking that the United States did not interpret § 504 to forbid unnecessary institutionalization of persons with mental disabilities as a condition to their receiving services, and they are equally wrong that the pre-ADA decisional law under § 504 uniformly rejected that position.

From the start, the Department of Justice took the position that unnecessary institutionalization of the mentally-disabled violated § 504 of the Rehabilitation Act. This position was advanced by the United States as *amicus curiae* in cases brought by individuals with disabilities,<sup>47</sup> and as plaintiff in the *Pennhurst* litigation.

The district court in *Pennhurst* found "that § 504 of the Rehabilitation Act of 1973 . . . provided a right to minimally adequate habilitation in the least restrictive environment."<sup>48</sup>

On appeal in *Pennhurst*, the United States, as appellee, filed two briefs urging affirmance, arguing vigorously in both that unnecessary institutionalization violates § 504.<sup>49</sup> The Third Circuit affirmed the district court's judgment on the basis of another statute (the Developmentally Dis-

<sup>47</sup> See, e.g., Post-Trial Memorandum of the United States, in *Kentucky Association for Retarded Citizens v. Conn.*, Civ. Ac. No. C-78-0157-L(A), W.D. Ky. (filed June 18, 1979), at 5-26; Post-Hearing Brief of Plaintiffs and Amicus Curiae United States, in *Wyatt v. Hardin*, Civ. Ac. No. 3195-N, N.D. Ala. (filed Feb. 18, 1979), at 186-88.

<sup>48</sup> 451 U.S. at 7, describing *Halderman v. Pennhurst State Sch. & Hosp.*, 446 F. Supp. 1295, 1323-24 (E.D. Pa. 1977).

<sup>49</sup> Brief for the United States to the Court of Appeals for the Third Circuit, Nos. 78-1490 et al. filed Oct 2, 1978, at 39-45; Supplemental Brief for the United States filed Aug. 14, 1979, at 2-10.



abled Assistance and Bill of Rights Act, hereinafter the "DD Act"), and thus found it unnecessary to address § 504. *Halderman v. Pennhurst State Sch. & Hosp.*, 612 F.2d 84, 107-08 (3rd Cir. 1979) (en banc).

In this Court, the United States urged that if the Third Circuit were reversed in its interpretation of the DD Act, "the case should be remanded to the court of appeals to consider the district court holding[] concerning . . . Section 504."<sup>50</sup> This Court reversed the Third Circuit's interpretation of the DD Act, and remanded to that court "those issues it did not address," including "respondents' . . . claims under § 504." 451 U.S. at 31.

On remand, the United States, now the Reagan Administration, filed a brief in the Third Circuit that again contended that the unnecessary institutionalization of an individual when community facilities are available violates § 504.<sup>51</sup> This brief differed from the earlier ones in that it expressed doubt whether the obligation would apply if it required a state to "create or expand" existing community services, citing this Court's intervening ruling in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), that § 504 does not require "affirmative action." This time, the Third Circuit held that unnecessary institutionalization violated state law, and again found it unnecessary to decide the § 504 question. 673 F.2d 647, 660-61 (3rd Cir. 1982). This Court reversed the state law ruling as violative of the Eleventh Amendment, and once again remanded the § 504 claim. 465 U.S. 89, 125 (1984). The case was then settled.

This history shows, first, that the earliest and contemporaneous administrative interpretation of § 504 was that it forbade unnecessary institutionalization of persons with

<sup>50</sup> Brief for the United States in Nos. 79-1404 et al., at 4 n.5.

<sup>51</sup> Brief for the United States in the Third Circuit, Nos. 78-1490 et al., filed October 14, 1981, at page 27.

mental disabilities. Second, while a later administration slightly adjusted this position, that adjustment was made in perceived deference to this Court's declaration in *Davis* that § 504 does not require "affirmative action." A few years later, this Court clarified that it had not meant in *Davis* to suggest that § 504 does not require affirmative steps of accommodation, but only that it does not require substantial modifications that would fundamentally alter the program in question. *Alexander v. Choate*, *supra*, 469 U.S. at 300-01, n.20. With the Court's clarification in *Alexander*, the administration's perceived need to adjust its position disappeared.

Petitioners are also wrong in suggesting that the lower court decisional law was uniformly against an interpretation of § 504 that forbade unnecessary institutionalization. In addition to the district court in *Pennhurst*, at least two other district courts ruled that § 504 did so forbid. *Homeward Bound Inc. v. Hissom Mem. Ctr.*, No. 85-C-437-E, 1987 WL 27104 (N.D. Okla. July 24, 1987); *Lynch v. Maher*, 507 F. Supp. 1268, 1278-80 (D. Conn. 1981).

Although petitioners cite six decisions reaching the contrary result, three of those post-dated the enactment of the ADA in July 1990 and thus could hardly have affected Congress' understanding when it enacted the ADA.<sup>52</sup>

There were, therefore, three lower court decisions rejecting the United States' position prior to enactment of the ADA, but those do not merit the importance Petitioners attach to them, for two reasons. First, the fact that lower court decisional law was mixed removes entirely the claim that Congress "must have" intended to

<sup>52</sup> *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. Sept. 6, 1990); *Jackson v. Fort Stanton Hosp. & Training Sch.*, 757 F. Supp. 1243 (D. N.M. Dec. 1990), *rev'd on other grounds*, 964 F.2d 980 (10th Cir. 1992); *People First of Tenn. v. Arlington Developmental Ctr.*, 878 F. Supp. 97 (W.D. Tenn. 1992).

endorse the holdings Petitioners prefer. Indeed, Congress was explicit in the committee reports that it disapproved of much of the decisional law under the Rehabilitation Act. See H. Rep. IV at 24 ("Moreover, 17 years of experience with section 504 . . . and in the interpretation of [that] law have demonstrated the need for further legislative action in this area."); see also, Hearing before the Senate Committee, *supra* n.21, at 195 (Test. of Dick Thornburgh) ("Fifteen years have gone by since the Rehabilitation Act took effect. Nevertheless, persons with disabilities are still too often shut out of the economic and social mainstream of American life."). Congress included § 2, and another change in the statutory text cited below, for the express purpose of preventing similar misinterpretations of the ADA. See pp. 17-18 *supra*; pp. 42-44 *infra*. Finally, none of the cases cited by Petitioners is mentioned anywhere in the legislative history of the ADA.

**(2) Petitioners' Assumption That the Text of the ADA Is the Same as Section 504 Is Wrong.**

Those courts that construed § 504 not to ban unnecessary institutionalization were heavily influenced by three textual considerations that Congress changed in the ADA. Two related to the text of the statute, and are discussed in this section. The third related to the text of the regulations, and is discussed in the next section.

First, the Rehabilitation Act banned discrimination only if "solely by reason of . . . disability." The word "solely" was removed in the ADA, Congress explaining that it had led to decisions it did not approve.<sup>53</sup>

Second, § 504 of the Rehabilitation Act was a one-sentence statutory command, lacking both the definitions of "discrimination" that appear in § 2 of the ADA and the explicit congressional endorsement of a stand-alone "most integrated setting" regulation that appears in

<sup>53</sup> S. Rep. at 44; H. Rep. II, at 85.

§ 204(b) of the ADA. Courts regularly expressed uncertainty about the meaning of the non-specific § 504.<sup>54</sup>

**(3) Petitioners' Assumption That the § 504 Coordination Regulations Were at Issue in the Pre-ADA § 504 Cases Is Wrong.**

The third textual difference between the pre-ADA § 504 cases and the ADA itself is that the stand-alone "most integrated setting" command that appeared in the § 504 coordination regulations, and that was the model for the ADA § 35.130(d) regulation, was not at issue in the § 504 cases petitioners cite.

The applicable regulations in those cases (to the extent they were even raised) were HEW's Part 84 Rehabilitation regulations (codified at 45 CFR Part 84). Those were the regulations that applied to recipients of federal funds distributed by HEW. The Part 84 regulations did not have a clear stand-alone integration requirement. Rather, they had a reference to "most integrated setting" that was melded into the provisions directing that persons with disabilities be provided access to the programs in which the nondisabled participate, see 45 CFR § 84.4(b)(2), and that unfortunate placement led the courts in the cases invoked by petitioners to construe it (contrary to the United States' position) as limited to such programs.<sup>55</sup>

By contrast, the coordination regulations (adopted a year later, and codified at 45 CFR Part 85, and later recodified as 28 CFR Part 41 when coordination authority was transferred from HEW to the Attorney General in 1980) did contain a clear stand-alone integration requirement (which is quoted *supra* at p. 20). However, the coordination regulations served only as guidance to other federal agencies in fashioning their own regulations

<sup>54</sup> See, e.g., *ADAPT v. Skinner*, 881 F.2d 1184, 1193 (3rd Cir. 1989) (*en banc*) (there is an "absence of a clear congressional mandate" in § 504).

<sup>55</sup> In effect, the Part 84 regulations placed the "most integrated setting" obligation in the equivalent of what is now § 35.130(b).



to apply to the recipients of the federal funds they administered. See 45 CFR § 85.4. Because the coordination regulations were expressly addressed solely to federal agencies, they did not apply to the recipients of the federal funds who were sued in the cases cited by petitioners. Thus, the coordination regulations were not invoked by any party in those cases, and were not construed by the courts in any of those cases.

In the ADA, Congress expressly instructed the Attorney General to promulgate regulations that make operative the unqualified, stand-alone "most integrated setting" requirement of the coordination regulations. The fact that lower courts reached mixed rulings on the meaning of § 504 thus reflects nothing about the meaning of the words in the coordination regulations, for those words were never interpreted. They were made operative upon providers of disability services only with Congress' express embrace of them in the ADA.

Precisely because of the differences between § 504 and the ADA just recounted, two of the three courts which rendered pre-ADA decisions under § 504 cited by petitioners have reached the opposite result under the ADA. (Pet. Cert. App. 19a) (distinguishing the Eleventh Circuit's prior decision in *S.H. v. Edwards*, *supra*, as well as the other § 504 decisions invoked by petitioners, because "none of the cases cited by the State involved claims under the express integration regulation of either the ADA or the § 504 coordination regulations"); *Helen L.*, *supra*, 46 F.3d at 333-34 (distinguishing the Third Circuit's prior decision in *Clark v. Cohen*, 794 F.2d 69 (3d Cir. 1985), *cert. denied*, 479 U.S. 962 (1986), on the same ground.)

**B. "Pennhurst Lite:" The Contention That This Court's Decision in *Pennhurst* Controls the Disposition of This Case.**

Petitioners contend that reversal of the decision below follows *a fortiori* from the decision in *Pennhurst*, which

construed the "bill of rights" provision of the DD Act as not imposing an enforceable obligation upon states to treat mentally retarded persons in the setting that is least restrictive of their personal liberty. (Pet. Br. 33-35). That contention overlooks the critical differences between the statutes in the two cases, as well as the changes in the funding of mental disability services and in the legislative climate in the fifteen years between enactment of the DD Act and the ADA.

The statute in *Pennhurst* was a spending statute. The funds made available were quite small, in relation to the overall cost of treating mentally retarded persons. The Court found "[n]oticeably absent from" the bill of rights in the DD Act "any language suggesting that [the furnishing of those rights] is a 'condition' for the receipt of federal funding." 451 U.S. at 13.

The Court concluded that the bill was predicated solely on the Spending Clause, and applied only to States that elected to receive the funds proffered in exchange for agreeing to accept the conditions imposed by the statute for such receipt. *Id.* at 15-16, 18-19. Such legislation, the Court explained, is quite different from traditional regulatory legislation, and "is much in the nature of a contract." *Id.* at 17. This requires a particular mode of interpretation to protect the voluntary nature of the State's participation:

The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the "contract." . . . There can, of course, be no knowing acceptance if a State is unaware of the condition or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on

the grant of federal moneys, it must do so unambiguously. [*Id.* at 17.]<sup>56</sup>

The Court concluded, from the precatory nature of the language in the bill of rights, that it was merely an expression of considerations that justified and supported Congress' appropriation of money under the Act, and as such was "hortatory, not mandatory." *Id.* at 24.

The Court was reinforced in this interpretation by other considerations. First, the Secretary of HEW, the agency responsible for administering the statute, "has specifically rejected the position of the Solicitor General" that the bill of rights is mandatory. *Id.* at 23. Second, the Court thought it unlikely that Congress would mandate so compelling an obligation while proffering so small a portion of the cost:

The fact that Congress granted to Pennsylvania only \$1.6 million in 1976, a sum woefully inadequate to meet the enormous financial burden of providing "appropriate" treatment in the "least restrictive" setting, confirms that Congress must have had a limited purpose in enacting [the bill of rights]. When Congress does impose affirmative obligations on the States, it usually makes a far more substantial contribution to defray costs. . . . [*Id.* at 24.]

Every one of the considerations cited by this Court in *Pennhurst* as important to its decision cuts in the opposite direction here. Title II of the ADA is not an exercise of Congress' spending power, but a mandatory obligation imposed upon all public entities. Its language is not hortatory, but mandatory. The agency charged by Congress with responsibility to interpret and enforce the statute is

<sup>56</sup> See also, *Cedar Rapids Community School District v. Garret F.* No. 96-1793, 1999 WL 104410 (U.S. Mar. 3, 1999) (dissenting opinion of Justice Thomas, joined by Justice Kennedy) ("special rules of construction" for statutes "enacted pursuant to Congress' spending power").

in complete accord with the interpretation of the court below. And, Congress has assumed the lion's share of the cost.

**C. "The Sky Is Falling:" The Contention That Congress Could Not Have Intended, Without Clearer Articulation, to Have Imposed on the States Massive Fiscal and Administrative Burdens.**

Petitioners, and more emphatically the dwindling minority of states appearing as *amici curiae* in Petitioners' support,<sup>57</sup> conjure up enormous costs that would attend the interpretation reached by the court below. This, they suggest, could not have been what Congress intended, and points against a literal interpretation of the "most integrated setting" requirement. There are two discrete answers to this contention.

1. First, the massive costs prophesized are nonexistent, and Congress knew that when it enacted the ADA. There was, by 1990, overwhelming evidence that it is much less costly to provide mental disability services in the community than in institutions (as well as virtually unanimous professional opinion that treatment is better when provided in the community). Congress knew this well; indeed, it was what prompted Congress to amend the Medicaid program in 1981 and 1986 and thereby assume the primary burden of the costs of providing mental disability services in the community. See pp. 3-4, *supra*. The cost advantages of providing mental disability services in the community, and the knowledge thereof in 1990, are described at length in the Brief *Amici Curiae* of Former State Commissioners. See also, pp. 3-4, *supra*.

<sup>57</sup> The "sky is falling" tone of the states' brief is particularly curious, as, with the exception of one case in Montana, all of the pending cases it describes are from states that elected not to join the brief.



Because it is so much cheaper to do so, the vast majority of states have reallocated major portions of their mental health budgets to expanding community services and closing or downsizing institutions. See, Brief *Amici Curiae* of Former State Commissioners.

To be sure, a handful of states, including Georgia, have dragged their heels. The reasons for that have nothing to do with the quality of treatment and/or the relative costs of providing it in institutions or the community. Instead, they have everything to do with politics. There are strong forces resisting the move to community service, out of self-interest and/or antipathy to those with disabilities:

The Former State Commissioners' brief cites the heavy lobbying of unions representing employees in institutions. So here, the record shows that Georgia officials have hesitated to eliminate jobs in institutions. See p. 10, *supra*.

The Commissioners also note the self-interest of the officials who run these institutions, who are reluctant to surrender their turf. So here, the administrators' avowed mission was to "staff the beds" in the institution. See p. 10, *supra*.

The interests mentioned so far are understandable, but they are not reasons for segregating persons whose disabilities do not require segregation. This Nation would not tolerate the continued imprisonment of persons known to be innocent, out of concern for jobs and administrative prerogatives. Nor did the economic advantages that accrued from slavery serve as justification for resisting the Thirteenth Amendment. The ADA's conferral of civil rights upon the disabled makes those interests equally irrelevant as justifications for resisting desegregation here.

But the reasons for heel-dragging in the holdout states include other less worthy considerations. As the Former State Commissioners note, and as this Court recognized in *Cleburne*, there are elements of the citizenry who pre-

fer the states' former policy of segregating persons with mental disabilities.<sup>58</sup> And, as the record of this case shows in abundance, bureaucratic indifference and ignorance has contributed to the unnecessary isolation of the mentally disabled in institutions. See pp. 6, 9-10, *supra*.

Costs are a pretext voiced in the courts by states seeking to delay compliance with the ADA. That they are pretextual is evidenced by the fact that the same state officials acknowledge in non-judicial settings the very opposite of what they proclaim in their brief *amici curiae* here. See pp. 10-11, *supra*; and see Brief *Amici Curiae* of American Ass'n on Mental Retardation *et al.*

2. Assuming, *arguendo*, that in a particular case (unlike this one) a state would have to incur increased costs to provide treatment in the community to a person who could appropriately be served there, the ADA contains provisions that would allow the court to consider the burden upon the state, and, where undue, to adjust relief to address it.

Congress clearly contemplated that states might have to absorb some additional costs to achieve compliance with Title II, especially costs of a transitional nature.<sup>59</sup> That is an inevitable consequence of superimposing a ban on impermissible discrimination upon a regime that was constructed in an era of discrimination and neglect.

However, Congress took precautions in the statute to protect public entities against burdens that would be undue, as the court below held. See pp. 12-13, *supra*.

<sup>58</sup> These political problems were also identified by Kathryn Power, quoted in one of the briefs supporting petitioners. NCSL Brief, at 3a.

<sup>59</sup> Senator Hatch observed that the ADA would "impose a lot of expenses and rightly so . . . It is time we brought persons with disabilities into full freedom, economic and otherwise, with other citizens in our society. This bill will do that. In doing so, we should be aware that it is going to be costly . . ." 135 Cong. Rec. 19835 (1989).

Petitioners chose not to ask this Court to review the Eleventh Circuit's articulation of the defense afforded them, and, in these circumstances, it would be premature to explore the precise dimensions of the defense that public entities enjoy. Petitioners, of course, will be free to pursue that question further in their pending appeal from the district court's decision on remand, although the record in this case affords them little comfort no matter how that defense is ultimately defined.

#### D. Avoiding Constitutional Questions.

This Court limited its grant of certiorari to the issue of statutory interpretation. Petitioners nonetheless revive their constitutional claim by urging this Court to reject the construction below to avoid the constitutional question.

The asserted constitutional difficulty is a non-starter. The findings made by Congress, compiled after extensive hearings, identify a wide spectrum of discriminatory practices visited by public entities upon persons with disabilities, including isolation and segregation in mental institutions. This Court recognized in *Cleburne* that eliminating discrimination against persons with mental disabilities is an appropriate topic for remediation under the Equal Protection Clause.

Moreover, Congress also predicated the ADA upon the Commerce Clause, see § 2(b)(4), finding that discrimination against those with disabilities precludes their access to the community, depriving the economy of their working potential and their patronage. The ADA's most integrated setting requirement—which has as its declared purpose bringing persons with disabilities into “the economic and social mainstream of American life” (see p. 28, *supra*) is surely within Congress' power under the Commerce Clause.

#### CONCLUSION

For the foregoing reasons, the decision below should be affirmed.

Respectfully submitted,

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## **APPENDIX**

**APPENDIX****ADDITIONAL STATUTORY AND  
REGULATORY PROVISIONS**

Section 2 of the Americans with Disabilities Act, 42 USC § 12101, provides:

**SEC. 2. FINDINGS AND PURPOSES.****(a) FINDINGS.—The Congress finds that—**

(1) some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older;

(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

(3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;

(4) unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;

(5) individuals with disabilities continually encounter various forms of discrimination, in-



cluding outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;

(6) census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally;

(7) individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society;

(8) the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals; and

(9) the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to com-

pete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity.

(b) **PURPOSE.**—It is the purpose of this Act—

(1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;

(2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;

(3) to ensure that the Federal Government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities; and

(4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

28 CFR § 35.130 provides:

§ 35.130 **General prohibitions against discrimination.**

(a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

(b) (1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability—

(i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

(vi) Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

(vii) Otherwise limit a qualified individual with a disability in the enjoyment of any right,

privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

(2) A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

(i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;

(ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or

(iii) That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.

(4) A public entity may not, in determining the site or location of a facility, make selections—

(i) That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or

(ii) That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, pro-



gram, or activity with respect to individuals with disabilities.

(5) A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.

(6) A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.

(7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

(8) A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.

(c) Nothing in this part prohibits a public entity from providing benefits, services, or advantages to

individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.

(d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

(e)(1) Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

(2) Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

(f) A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

(g) A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

APR 14 1999

CLERK

In The  
Supreme Court of the United States

October Term, 1998

TOMMY OLMSTEAD, Commissioner of the  
Department of Human Resources of the State of  
Georgia, RONALD C. HOGAN, Superintendent of  
Georgia Regional Hospital/Atlanta, and EARNESTINE  
PITTMAN, Executive Director of the  
Fulton County Regional Board,

v.

*Petitioners,*

L.C. and E.W., each by JONATHAN ZIMRING as  
guardian ad litem and next friend,

*Respondents.*

On Writ Of Certiorari To The United States  
Court Of Appeals For The Eleventh Circuit

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## TABLE OF CONTENTS

## Page

|  |    |
|--|----|
| 1. The text of the statute does not support this claim, and the "by reason of such disability" language affirmatively prohibits it.....  | 1  |
| 2. The Attorney General's authority to promulgate regulations "consistent with" other regulations "applicable to recipients of Federal financial assistance" under the Rehabilitation Act of 1973 does not support this claim..... | 4  |
| 3. The Attorney General's authority to promulgate regulations "consistent with this chapter" does not support this claim.....  | 5  |
| 4. The general language of Title IIA cannot implicitly repeal or displace the vastly more specific provisions of the Medicaid Act.....   | 6  |
| 5. The Congressional findings in the ADA, 42 U.S.C. § 12101, do not support a "least restrictive care" reading of Title IIA.....   | 7  |
| 6. Title IIA of the ADA and § 504 of the Rehabilitation Act must be read to contain the same rule regarding least restrictive care .....   | 7  |
| 7. The triggering event of <i>Chevron</i> deference – an ambiguous statute – comes after, not before, all interpretive canons have been exhausted to ascertain the meaning of a law .....  | 8  |
| 8. Plaintiffs offer no meaningful response to the contention that the path followed in <i>Pennhurst</i> is the path that ought to be followed here .....   | 11 |

## TABLE OF CONTENTS – Continued

|   | Page |
|---|------|
| 9. The legislative history does not support a “least restrictive care” interpretation.....  | 12   |
| 10. Even if <i>Chevron</i> otherwise applies here, the Department of Justice’s regulation, and the agency’s new interpretation of it, do not deserve deference..... | 13   |
| 11. The Eleventh Circuit’s ruling itself constitutes a fundamental alteration of Georgia’s programs for providing health care to the mentally disabled....          | 14   |
| 12. The lower-court litigation history of § 504 does not support a least restrictive care interpretation of Title IIA.....  | 16   |
| 13. Plaintiffs’ rendition of the facts is misleading .....  | 16   |
| 14. Plaintiffs’ policy-based arguments are inaccurate and unpersuasive .....  | 18   |

## TABLE OF AUTHORITIES

|   | Page          |
|---|---------------|
| CASES   |               |
| <i>Alexander v. Choate</i> , 469 U.S. 287 (1985).....   | 9, 12         |
| <i>Atascadero State Hosp. v. Scanlon</i> , 473 U.S. 234 (1985).....   | 9, 10, 11, 12 |
| <i>Bowen v. American Hosp. Ass’n</i> , 476 U.S. 610 (1986) .....  | 9             |
| <i>Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.</i> , 467 U.S. 837 (1984) .....                                     | 8, 9, 10      |
| <i>City of Edmonds v. Oxford House, Inc.</i> , 514 U.S. 725 (1995).....   | 10            |
| <i>Clark v. Cohen</i> , 794 F.2d 79 (3rd Cir. 1985), <i>cert. denied</i> , 479 U.S. 962 (1986) .....                                  | 16            |
| <i>Doe v. Chiles</i> , 136 F.3d 709 (11th Cir. 1998).....   | 6             |
| <i>Doe v. Public Health Trust of Dade County</i> , 696 F.2d 901 (11th Cir. 1983).....   | 3             |
| <i>Garcia v. San Antonio Metropolitan Transit Auth.</i> , 469 U.S. 528 (1985).....  | 10            |
| <i>Gregory v. Ashcroft</i> , 501 U.S. 452 (1991).....   | 9, 10         |
| <i>Helen L. v. DiDario</i> , 46 F.3d 325 (3d Cir.), <i>cert. denied</i> , 516 U.S. 813 (1995) .....                                   | 4             |
| <i>Jackson v. Fort Stanton Hosp. &amp; Training Sch.</i> , 964 F.2d 980 (10th Cir. 1992).....   | 16            |
| <i>Kentucky Ass’n for Retarded Citizens, Inc. v. Conn.</i> , 674 F.2d 582 (6th Cir.), <i>cert. denied</i> , 459 U.S. 1041 (1982)..... | 16            |
| <i>Lechmere, Inc. v. NLRB</i> , 502 U.S. 527 (1992).....  | 9             |



## TABLE OF AUTHORITIES – Continued

Page

|  |                        |
|--|------------------------|
| <i>National Organization of Women, Inc. v. Scheidler</i> ,<br>510 U.S. 249 (1994).....           | 7                      |
| <i>P.C. v. McLaughlin</i> , 913 F.2d 1033 (2d Cir. 1990).....                                    | 16                     |
| <i>Pennhurst State Sch. &amp; Hosp. v. Halderman</i> , 451 U.S.<br>1 (1981).....                 | 4, 5, 7, 9, 10, 11, 13 |
| <i>Phillips v. Thompson</i> , 715 F.2d 365 (7th Cir. 1983).....                                  | 16                     |
| <i>Russello v. United States</i> , 464 U.S. 16 (1983).....                                       | 5                      |
| <i>Southeastern Community College v. Davis</i> , 442 U.S.<br>397 (1979).....                     | 9, 13                  |
| <i>Traynor v. Turnage</i> , 485 U.S. 535 (1988).....   | 9                      |
| <i>United States v. Board of Comm'rs of Sheffield, Ala-<br/>bama</i> , 435 U.S. 110 (1978) ..... | 5                      |
| <i>Youngberg v. Romeo</i> , 457 U.S. 307 (1982).....   | 15                     |

## STATUTES

|  |      |
|--|------|
| 20 U.S.C. §§ 1400 <i>et seq.</i> (1994 & Supp. II 1996)..... | 5    |
| 29 U.S.C. § 794 (1994) .....                                 | 7    |
| 42 U.S.C. § 12101 (1994).....                                | 7    |
| 42 U.S.C. § 12132 (1994).....                                | 1, 4 |
| 42 U.S.C. § 12134 (1994).....                                | 4    |
| 42 U.S.C. § 12134(a)(1994) .....                             | 6    |
| 42 U.S.C. § 12134(b) (1994) .....                            | 4, 5 |
| 42 U.S.C. §§ 1396 <i>et seq.</i> (1994 & Supp. II 1996)..... | 6    |
| 42 U.S.C. § 1396a(a)(8) (1994 & Supp. II 1996).....          | 6    |
| 42 U.S.C. § 1396a(a)(10)(A) (1994 & Supp. II 1996) .....     | 6    |
| 42 U.S.C. §§ 6000 <i>et seq.</i> (1994 & Supp. II 1996)..... | 5    |
| 42 U.S.C. § 6010 (1994 & Supp. II 1996).....                 | 11   |

## TABLE OF AUTHORITIES – Continued

Page

|  |               |
|--|---------------|
| Developmentally Disabled Assistance and Bill of<br>Rights Act of 1975, 42 U.S.C. §§ 6000 <i>et seq.</i><br>(1994 & Supp. II 1996)..... | 5             |
| Individuals with Disability Education Act, 20 U.S.C.<br>§§ 1400 <i>et seq.</i> (1994 & Supp. II 1996) .....                            | 6             |
| Rehabilitation Act of 1973, § 504, 29 U.S.C. § 794<br>(1994).....  | <i>passim</i> |
| O.C.G.A. § 37-3-1(10) (1995) .....   | 18            |
| O.C.G.A. § 37-3-161 (1995).....  | 18            |

## RULES AND REGULATIONS

|  |    |
|--|----|
| 28 CFR Part 35 (1991) .....                              | 14 |
| 45 CFR Part 84.4(b)(2), 42 Fed. Reg. 22676 (5-4-77) .... | 13 |
| 45 CFR Part 85, 43 Fed. Reg. 2132 (1-13-78) .....        | 14 |

## OTHER AUTHORITIES

|   |    |
|---|----|
| HOUSE COMM. ON ENERGY AND COMMERCE, 103D CONG.,<br>1ST SESS., MEDICAID SOURCE BOOK: BACKGROUND<br>DATA AND ANALYSIS 542 (Comm. Print 1993) .....  | 6  |
| DEPARTMENT OF JUSTICE, CIVIL RIGHTS DIVISION, FINAL<br>REGULATORY IMPACT ANALYSIS OF THE DEPARTMENT OF<br>JUSTICE REGULATION IMPLEMENTING SUBTITLE A OF<br>TITLE II OF THE ADA (12-18-91) ..... | 14 |

## TABLE OF AUTHORITIES – Continued

|   | Page |
|---|------|
| THE AMERICANS WITH DISABILITIES ACT, TITLE II TECHNICAL MANUAL, COVERING STATE AND LOCAL GOVERNMENT PROGRAMS AND SERVICES, 1993 EDITION (1994 Supp.) .....        | 14   |
| GENERAL ACCOUNTING OFFICE/HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, SUCCESSFUL STATE EFFORTS TO EXPAND HOME SERVICES WHILE LIMITING COSTS 4 (AUG. 1994)..... | 19   |

**1. The text of the statute does not support this claim, and the “by reason of such disability” language affirmatively prohibits it.** Of all the principles auditioning to govern this claim, the words of Title IIA of the Americans with Disabilities Act provide the most complete and final answer to the question whether Congress has itself compelled, or authorized the Attorney General to compel, the States to provide least restrictive care to their disabled citizens:

Subject to the provisions of this subchapter, no qualified individual with a disability shall, *by reason of such disability*, [1] be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or [2] be subjected to discrimination by any such entity.

42 U.S.C. § 12132 (1994) (emphasis added).

After two rounds of briefing, it is hard to discern how this 48-word provision, and the “by reason of” principle that firmly anchors it, could suddenly compel least restrictive treatment of the disabled. Here, for example, the language is being used to bar hospital services offered on a voluntary basis, unless at the same time the State fully funds all demand for another service – a community residential placement. Yet neither by providing voluntary hospital services nor by requiring a person to wait her turn for a community placement does the State “exclude[]” the disabled persons from any services “by reason of” their disability nor “discriminate[]” against the disabled “by reason of” their disability. It is a hallmark of everyday citizenship, not a mark of disability, to be eligible for some benefits when they become available (free housing, for example) and others on demand (police and fire protection). No civil rights statute of which we are aware has ever barred such an approach to allocating limited government benefits, to say nothing of doing so where the forbidden conduct consists only of differential treatment “by reason of” disability.

a. Plaintiffs first argue (Resp. Br. 21) that Title IIA does more than just ensure that the disabled receive the same access to State benefits and services provided to the non-disabled; it also regulates, they say, State services that are



provided solely to the disabled, such as mental health care. True enough, but only in situations not pertinent here. Yes, Title IIA by its terms would prevent the State from offering mental health care to its disabled citizens, then denying such care to an individual by reason of, say, blindness. And, yes, Title IIA would prevent the State from involuntarily confining an individual in a State hospital when medical judgment did not support it. But these limited exceptions only prove the general rule: the State does not discriminate "by reason of" disability when it allocates mental health services to its handicapped population in a facially neutral, voluntary, and even-handed way, which is all that happened here.

b. Plaintiffs and their amici next argue (Resp. Br. 16, 17, 21-22; APA Br. 12-14) that the provision bars States not just from excluding the disabled from specific programs or services but also bars discrimination by the government "in its overall provision of services." This apparently is taken to mean (Resp. Br. 17) that Title IIA "ban[s] public entities from requiring unnecessary segregation from the community as the price for receiving needed disability services" because such removal from the community is segregative and limits the individual's access to other government benefits and services, e.g., parks and other public common areas. This argument, however, blurs the distinction between voluntary and involuntary treatment, and also falsely assumes that the hospital itself does not provide a continuum of more and less restrictive care.

As to involuntary treatment, the State may not confine individuals in a hospital against their will unless their illness causes dangerousness or inability to care for themselves. This would be illegal under State law, the United States Constitution, and presumably the ADA. Such treatment would seem to implicate both ADA restrictions – "exclus[ion] from participation in . . . services . . . of a public entity" and "discrimination by such entity" – and would seem to do so "by reason of" disability. But that is not what happened here. As to L.C.'s and E.W.'s actual treatment history, plaintiffs take great liberties with the record, and blur the distinction between voluntary and involuntary treatment. A more extensive response

regarding the treatment that was provided is included in a later section of the brief. See *infra* at 18. But at this point it suffices to say that there is no dispute regarding the validity of their involuntary treatment under the ADA.

Voluntary treatment, by contrast, occurs once the patients consent to hospital treatment. At that point, they "carr[y] the key to the hospital's exit in [their] hand[s]" and must be permitted to leave if they are no longer at risk to themselves or others. *Doe v. Public Health Trust of Dade County*, 696 F.2d 901, 903 (11th Cir. 1983). Still, plaintiffs argue that after they became voluntary patients, the State had an obligation not just to offer to release them and to offer what are referred to as "day" services (e.g., medication and other medical care, counseling, vocational training), but as well to provide plaintiffs with another place to live that was closely supervised and monitored 24 hours a day. Like all disabled individuals, and all citizens generally when it comes to finite government services, however, plaintiffs were asked to wait their turn. Title IIA does not plausibly cover this everyday allocation of finite State resources. The State on this record is by no means forcing anyone to be "segregated," and it is exceedingly misleading to suggest otherwise. Unless the ADA bars the creation of State hospitals for the disabled in the first instance, which plaintiffs concede it does not (Resp. Br. 14), the provision of an optional hospital bed to those without a supervised home in no way "exclude[s]" the handicapped from government services or "discriminat[es]" against them "by reason of" their disability. Further, if Georgia "presumptive[ly]" (APA Br. 11) violates the ADA by not providing a highly supervised residential house as opposed to a hospital bed on demand, then surely it presumptively violates the ADA not to treat all such patients in the community or at a minimum violates the ADA not to create a community-care program in the first instance. The greater authority to decide to create a community-care program in the first instance, in short, includes the lesser authority to determine how many beds it should have.

**2. The Attorney General's authority to promulgate regulations "consistent with" other regulations "applicable to recipients of Federal financial assistance" under the Rehabilitation Act of 1973 does not support this claim.** Instead of finding textual support for their claim in the most logical place to put such a far-reaching requirement – within the provision that contains the "Discrimination" ban, 42 U.S.C. § 12132 (1994) – plaintiffs and their amici look principally (Resp. Br. 18-19, U.S. Br. 14-15) to another provision entitled "Regulations," 42 U.S.C. § 12134 (1994). That provision says that any regulations "shall be consistent with . . . the coordination regulations . . . applicable to recipients of Federal financial assistance" under the Rehabilitation Act of 1973. 42 U.S.C. § 12134(b) (1994). Through this language, plaintiffs claim (Br. 20), Congress "commanded" *in the statute* that the regulations issued under the Rehabilitation Act would become law under the ADA and, in doing so, Congress thereby mandated least restrictive care.

This argument fails, however, because the prior regulations never received a least restrictive treatment interpretation. To the extent the directive to promulgate regulations "consistent with" those passed under § 504 of the Rehabilitation Act creates any inference at all, in other words, plaintiffs have picked precisely the wrong one. A mandate to enact regulations "consistent with" pre-existing rules is a mandate to stick by those rules and the agency's interpretation of them, which conspicuously did not cover least restrictive care.

The federal government ultimately concedes the core premise of this reading. Even though the Rehabilitation Act was enacted in 1973, the government acknowledges (Br. 10) that it was not until more than 20 years later, in a 1994 amicus brief filed in *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir.), *cert. denied*, 516 U.S. 813 (1995), that the government first publicly articulated today's interpretation of the integration regulation. That was four years after the ADA was passed and thirteen years after the Court rejected a virtually identical effort to impose least restrictive care on the States under the Developmentally Disabled Assistance Act, see *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981), a

litigation exercise that can only be described as pointless if § 504 throughout that period of time covered precisely the type of mental-health care that the Court rejected in *Pennhurst*.

That leaves a related, but no less important, question. If the "integration" regulation did not require least restrictive care before 1994, what did it require? Consistent with the language of the statute it implemented, the integration regulation focused just on providing equal access to federally-funded government services. As shown below, all agency interpretations confirm this point and none made the regulations applicable to least restrictive care. See *infra*, at 14.

Quite apart from these problems, the single case cited for this theory of "incorporation" of existing regulations (Resp. Br. 20), see *United States v. Board of Comm'rs of Sheffield, Alabama*, 435 U.S. 110, 134 (1978), does not remotely extend to this setting. In *Sheffield*, unlike in this case, the Attorney General had "unambiguously" interpreted the statute in question and had reported his construction to Congress through testimony and exhibits. *Id.* at 131-135, nn.19-22.

**3. The Attorney General's authority to promulgate regulations "consistent with this chapter" does not support this claim.** Still less tenable is the related argument (Resp. Br. 23, U.S. Br. 14-15) that Congress authorized a least restrictive care regulation when it said that any regulations "shall be consistent with this chapter," 42 U.S.C. § 12134(b), which is to say consistent with Titles I and III of the ADA and the regulations promulgated under them. Had Congress wished to establish this benchmark of liability in Title II, however, it is implausible to think that it would have used language in Title I or Title III to do so. See *Russello v. United States*, 464 U.S. 16, 23 (1983).

Conspicuously missing from the responsive briefs, moreover, is any rejoinder to our opening contention (Pet. Br. 14-15, 34) that Congress knew how to use language regarding "least restrictive care," and yet did not do so here. See, e.g., Developmentally Disabled Assistance and Bill of Rights Act of 1975, 42 U.S.C. §§ 6000, et seq. (1994 & Supp. II 1996) ("least restrictive treatment" is a statutory goal for the



States); Individuals with Disability Education Act, 20 U.S.C. §§ 1400 et seq. (1994 & Supp. II 1996) (a free "appropriate" education is required of the States). Congress's decision in Title IIA of the ADA *not* to use language that has imposed such affirmative goals or requirements before and, more, to use language that contradicts these requirements – the "by reason of" limitation – deserves far more respect than plaintiffs have given it.

**4. The general language of Title IIA cannot implicitly repeal or displace the vastly more specific provisions of the Medicaid Act.** Plaintiffs do not dispute that the Medicaid laws, 42 U.S.C. §§ 1396 et seq. (1994 & Supp. II 1996) express a policy preference for treatment in institutions over treatment in the community. They simply point out (Resp. Br. 3, 32; U.S. Br. 25-26) that the law was amended to "permit" states to secure community-based care through special "waiver" programs. This response, however, does not come to grips with the fact that the Medicaid Act addresses in excruciating detail the issues involved in determining when institutional care should or should not be provided, and in determining when community care should or should not be provided. The Act thus favors, allocates billions of dollars for, and highly regulates institutional care. By contrast, Congress more recently has merely *allowed* states to shift toward alternative non-institutional care through its waiver programs. HOUSE COMM. ON ENERGY AND COMMERCE, 103D CONG., 1ST SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 542 (Comm. Print 1993). The waiver programs are optional for the states, unlike, for example, institutional nursing home services which are mandatory, 42 U.S.C. §§ 1396a(a)(10)(A) (1994 & Supp. II 1996), and community care is specifically limited by the number of "waiver slots" made available, unlike institutional services for the mentally disabled which must be made available on demand. 42 U.S.C. § 1396a(a)(8) (1994 & Supp. II 1996); *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998). The complex framework of the Medicaid Act, therefore, contemplates two appropriate and necessary options for treatment of developmentally disabled persons needing the same level of care – the one on demand for

eligible individuals (institutional treatment) and the other only when specifically approved and only according to a limited supply (community treatment). The DOJ's interpretation of the general language of Title IIA and the integration regulation in the end would suddenly convert these waiver programs from limited, optional programs to unlimited mandatory ones, all without any evidence of a meaningful public debate on this point either in Congress or in the Department of Justice.

**5. The Congressional findings in the ADA, 42 U.S.C. § 12101, do not support a "least restrictive care" reading of Title II.** The final textually rooted argument raised by plaintiffs and their amici (Resp. Br. 17-18, U.S. Br. 12) is that several congressional findings, situated in the preamble to the ADA, support their position. These highly generalized statements, however, do not mandate or by themselves authorize "least restrictive care" regulations. They simply support the notion that States may not involuntarily "segregate" the handicapped by excluding them from public services and benefits provided to the nonhandicapped. Nor may these admirable, but still hortatory, sentiments contradict the text's "by reason of" disability requirement. *National Organization of Women, Inc. v. Scheidler*, 510 U.S. 249, 260 (1994); cf. *Pennhurst, supra*.

**6. Title IIA of the ADA and § 504 of the Rehabilitation Act must be read to contain the same rule regarding least restrictive care.** In responding to the State's contention that the meaning of Title IIA can be gleaned from § 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) (1994), plaintiffs and their amici contend that the meaning of § 504 was not settled by 1990 and therefore that the ADA may still be construed to impose a least restrictive care requirement. But this argument presupposes, correctly in our view, that the two nearly-identical provisions must be given the same reading, either to the effect that they both require least restrictive care or that they both do not. It would suspend customary assumptions about the passage and implementation of legislation to believe that language first enacted in 1973 has just now been found to authorize such a requirement.

In the alternative, plaintiffs elsewhere suggest (Br. 42-43) that the ADA may go further on this issue than § 504 of the Rehabilitation Act does. That approach, however, creates more problems than it solves. The notion that one of these statutes authorizes a least restrictive treatment requirement, while the other does not, asks a lot of the modest differences between the two laws (i.e., the removal of the word "solely" in the ADA, the general findings of congressional purpose added to the ADA, and the admonition to make the ADA regulations "consistent with" their Rehabilitation Act counterparts). This contention also awkwardly suggests that Congress chose to impose a greater regulatory and fiscal burden on the States in a statute enacted without regard to whether federal funding was involved (the ADA) than in a statute enacted only to apply to those receiving federal funding (the Rehabilitation Act). That gets the customary assumptions about congressional regulation of the States exactly backwards.

**7. The triggering event of *Chevron* deference – an ambiguous statute – comes after, not before, all interpretive canons have been exhausted to ascertain the meaning of a law.** Plaintiffs and their amici place most of their eggs in the *Chevron*-deference basket, arguing not that Title IIA of the ADA requires least restrictive care, but that sufficient ambiguity clouds the question so that the Department of Justice was entitled to pass regulations to that effect. See *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). But, in doing so, they skip an important step. The conclusion that a statute is ambiguous, thereby triggering *Chevron* deference, comes at the end, not the beginning, of the quest for meaning and most importantly after all interpretive tools have been used. *Id.* at 843, 845-853.

a. *Chevron*, to start with, does not allow an executive agency to disregard the text of a statute. As shown, the language of Title IIA is utterly inconsistent with the least restrictive care mandate that the Attorney General has proposed.

b. *Chevron* also bars an agency from overriding relevant interpretations of a statute previously issued by this Court. *Lechmere, Inc. v. NLRB*, 502 U.S. 527, 536 (1992). Whatever else the Department of Justice may do regarding interpretations of § 504 or Title IIA, then, its interpretations may not disregard the Court's.

Except briefly to describe the litigation positions in *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), *Alexander v. Choate*, 469 U.S. 287 (1985), and *Traynor v. Turnage*, 485 U.S. 535 (1988), and to ignore *Bowen v. American Hosp. Ass'n*, 476 U.S. 610 (1986), altogether, plaintiffs and their amici offer no meaningful response to these prior interpretations of § 504 and the inconsistency between those limiting decisions and the expansive regulation they are advancing. *Davis*, *Choate* and *Bowen* cannot coexist with a requirement presumptively to subsidize every nursing-home and mental-health patient's request for a supervised residential bed, as opposed to an institutional bed. And surely if the State need not extend a benefit to all categories of handicapped persons under § 504 (*Traynor*), it may choose to allocate a limited supply of one government benefit (e.g., residential housing) to an entire category of handicapped individuals on a first-come-first-served basis.

c. Nor does *Chevron* allow plaintiffs and their amici to sidestep the plain statement rule. The clear statutory language that this canon requires precludes the ambiguity-prompted regulation that the Department of Justice has innovated. Whether in the area of Spending Clause legislation like the Developmentally Disabled Assistance Act at stake in *Pennhurst*, or legislation designed to abrogate a State's Eleventh Amendment immunity like the legislation at stake in *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 242 (1985), or legislation that affects traditional areas of State sovereignty like the age discrimination laws at stake in *Gregory v. Ashcroft*, 501 U.S. 452 (1991), or (we submit as well) legislation under § 5 of the Fourteenth Amendment that is premised on prior or threatened constitutional violations, the Court will not lightly infer congressional intrusion into these sovereignty-sensitive subjects. See *id.* at 468-70.



Even the most aggressive interpretation of *Chevron* cannot overcome this doctrine. Otherwise, the statutory ambiguity in the DDA at issue in *Pennhurst* would have allowed the applicable federal agency, or as here the Department of Justice, to promulgate a regulation requiring least restrictive care; the statutory ambiguity in *Atascadero* would have allowed the applicable agency to pass a regulation exposing the States to money damages; and the statutory ambiguity in the federal age discrimination law at issue in *Gregory* would have allowed an executive-branch agency to make the law applicable to State judges. To state the problem this way, it seems to us, is to answer it. *Chevron* does not trump this time-respected canon, converting a requirement of clear statement into one of clear silence. Nor, as we have shown (Pet. 43-44) and as plaintiffs and the federal government have yet to respond, would this application of *Chevron* be consistent with *Garcia v. San Antonio Metropolitan Transit Auth.*, 469 U.S. 528, 550-54 (1985).

At least two of these applications of the clear-statement rule are pertinent here, even though just one of them would suffice to reverse the Eleventh Circuit's decision. In the first place, Title IIA has a Spending Clause lineage. Patterned after § 504 of the Rehabilitation Act (which applies only to "recipients of federal funding") and worded in all pertinent respects just like it, Title IIA must be construed similarly to this Spending Clause legislation. See *Atascadero*, 473 U.S. at 246-47 & n.5 (assuming for the sake of argument that § 504 constitutes Spending Clause legislation). Neither § 504 nor Title IIA can meet the *Pennhurst* clear-statement hurdle.

A clear statement is also required because the Court will not infer such a sudden intrusion into traditional local authority unless clearly stated. See *Gregory*. *Pennhurst*, once again, points the way, because it indicates that deinstitutionalization would lead to "massive" changes at the local level. 451 U.S. at 24. For this reason, *City of Edmonds v. Oxford House, Inc.*, 514 U.S. 725, 732 n.5 (1995), a case dealing merely with zoning restrictions under the Fair Housing Act, is simply inapposite. Even under the test of *City of Edmonds*, moreover, federal direction as to how States should treat those who

cannot care for themselves and a directive that they do so in the least restrictive setting would lead not just to massive changes at the local level but would clearly implicate "a decision of the most fundamental sort." *Id.*

**8. Plaintiffs offer no meaningful response to the contention that the path followed in *Pennhurst* is the path that ought to be followed here.** Two basic responses are offered to the view that *Pennhurst* supplies dispositive guidance here. Plaintiffs argue (Br. 45) that the law at issue in *Pennhurst* involved Spending Clause legislation while the ADA does not. But this view assumes that § 504 of the Rehabilitation Act, which appears to be Spending Clause legislation, see *Atascadero*, and Title IIA of the ADA, which is not, should receive different interpretations. That disregards precedent from this Court, to say nothing of the overriding principle of common sense, that two provisions given the same words should be given the same interpretation. The federal government has not joined in this argument.

What the federal government does say (Br. 28-29), however, does no better. It contends that *Pennhurst* is inapplicable because the DDA said that treatment "should be provided in the setting that is least restrictive of the person's personal liberty," while the ADA says that "no qualified individual with a disability shall, by reason of such disability . . . be subject to discrimination." Yet when one statute says something specifically "should" be done ("least restrictive care") and another says something generally "shall" not be done ("discrimination"), neither law supplies a clear statement regarding least restrictive care. This argument also overlooks other language in the *Pennhurst* statute, which said that "[p]ersons with developmental disabilities have a right to appropriate treatment," and that the States "have an obligation" to provide care that is "appropriate to the needs of such persons." 451 U.S. at 13 (quoting 42 U.S.C. § 6010). Surely a decision that this language does not compel least restrictive or the most appropriate care compels a like conclusion under the far less specific terminology of Title IIA of the ADA.

9. **The legislative history does not support a "least restrictive care" interpretation.** Plaintiffs devote large sections of their brief (e.g., Br. 25-32) to the proposition that the legislative history supports their interpretation. The long and the short of it, however, is that even this exhaustive search has not located a single discussion regarding the complex issue of how, when and whether mental health care needs must be provided in a community as opposed to a hospital setting. Only a most reckless legislature would take on the multifaceted subject of deinstitutionalization, then establish an across-the-board value judgment about it, all without any testimony from those in the field, without any consideration of the appropriate number of State hospital beds that must remain in the States, without any consideration of how this new requirement would be paid for (particularly when it comes to purchasing the types of residential homes plaintiffs have requested), without any discussion of how this new requirement would interrelate with Medicaid funding and requirements, and most essentially without any discussion of the risks of unduly rapid deinstitutionalization. No party has identified any meaningful discussion in the hearings, committee reports or floor debates regarding the alleged requirement that residential housing be presumptively supplied on demand to those who no longer must be involuntarily committed to a State hospital. The same deficiency undermined the effort to broaden § 504 in *Choate*. Yet, there, "nothing in the pre- or post-1973 legislative discussion of section 504," the Court reasoned, "suggests that Congress desired to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid." 469 U.S. at 307. A like conclusion applies here.

To the extent legislative history has any bearing on this subject, moreover, it may be used only to resolve statutory ambiguities, not to establish a "clear statement" of legislative meaning. *Atascadero*, 473 U.S. at 242. The virtual concession that ambiguity clouds this question of statutory interpretation,

in other words, is fatal to this contention. Under no circumstance may legislative history supply a clear statement that Congress failed to supply in the text.

10. **Even if *Chevron* otherwise applies here, the Department of Justice's regulation, and the agency's new interpretation of it, do not deserve deference.** In response to the State's argument that the Department's new interpretation is not entitled to deference because it has been inconsistent, plaintiffs (Br. 39-41) and the Department (Br. 25) both claim that various briefs filed by the United States in *Pennhurst* represent a consistent interpretation. The Department states that it argued in *Pennhurst* that "in certain circumstances, Section 504 prohibits unnecessary institutionalization. . . ." Br. 25. But the government cannot hide its interpretive reversal under these overly broad generalizations encompassing vastly different interpretations. The government makes a partial concession here that its prior position was that, under *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), "a State could not be required to create a new system of community facilities where none existed before." *Id.*, citing U.S. Br. at 29, *Halderman v. Pennhurst State Sch. & Hosp.*, No. 78-1490 (filed Oct. 14, 1981). In fact, the government conceded more in its 1981 brief: "The issue here is not whether Section 504 would require Pennsylvania to create or expand a system of community facilities. Nor does the United States urge any such interpretation of the statute." U.S. Brief at 27, *Halderman v. Pennhurst State Sch. & Hosp.*, No. 78-1490 (filed Oct. 14, 1981). That interpretation would have precluded the adverse decision here, since there were no available places in Georgia's existing program before the plaintiffs' placements were provided.

In the final analysis, the government has not been able to point to any interpretive material supporting their current expansive interpretation. And in the most logical places to find such statements, deinstitutionalization was not mentioned at all: (1) the Department of Health, Education and Welfare's original regulations, 45 CFR Part 84.4(b)(2), 42 Fed. Reg. 22676, 22679 (5-4-77); (2) HEW's coordination regulations,



45 CFR Part 85, 43 Fed. Reg. 2132 (1-13-78); (3) the Department of Justice's Final Rule, 28 CFR Part 35; (4) DEPARTMENT OF JUSTICE, CIVIL RIGHTS DIVISION, FINAL REGULATORY IMPACT ANALYSIS OF THE DEPARTMENT OF JUSTICE REGULATION IMPLEMENTING SUBTITLE A OF TITLE II OF THE ADA, 12-18-91); or (5) DEPARTMENT OF JUSTICE, THE AMERICANS WITH DISABILITIES ACT, TITLE II TECHNICAL MANUAL, COVERING STATE AND LOCAL GOVERNMENT PROGRAMS AND SERVICES, 1993 EDITION (1994 Supp.). Most notably, the Regulatory Impact Analysis of Title IIA, which was prepared by the Justice Department itself, concluded the law would not have a significant impact. The report states that "it seems relatively clear that its overall economic impacts are likely to be quite minor. Title IIA essentially operates to extend the 'program accessibility' standards of the Rehabilitation Act of 1973 to the last small remaining portion of the public sector not yet covered by those standards." *Id.* at 4. The report concluded by stating that "Subtitle A of title II, therefore, should be regarded as being at most a minor extension of the Rehabilitation Act standards to the last remaining portion of the public sector." *Id.* at 22. Finally, "[t]he litigation expenses attributable to subtitle A title II are likely to be minimal, given that it imposes only the *now-familiar* standards of the Rehabilitation Act upon a group of entities knowledgeable about its requirements." *Id.* at 24 (emphasis added). No State was "familiar" with such a deinstitutionalization mandate before 1990, and none had reason to expect one after 1990.

**11. The Eleventh Circuit's ruling itself constitutes a fundamental alteration of Georgia's programs for providing health care to the mentally disabled.** Much is made in the opposition briefs of the "fundamental alteration" defense the State may assert on remand. But, in pushing the availability of this defense and in trying to craft an argument that offers all things to all people, plaintiffs make at least three mistakes.

First, plaintiffs and their amici incorrectly suggest that institutional treatment is generally "unnecessary" and thus constitutes discrimination in almost every circumstance, a position to which the Eleventh Circuit subscribed. If "at a given time the patients could be treated in the community" by

being provided whatever level of care they need regardless of cost, the court held, then institutional treatment presumptively constitutes discrimination. Pet. 22a-23a. But since virtually anyone "can" be treated in the community given unlimited funds (J.A. 138), this analysis approaches, if not reaches, the conclusion that institutional treatment is *per se* discrimination. By limiting considerations of cost only to the expenses of these two individuals as opposed to all individuals who might want such care, moreover, the court of appeals, and now plaintiffs, have completely foreclosed any meaningful defense. Pet. 29a. Not surprisingly, the district court on remand has already refused to admit the State's evidence concerning the system-wide impact of providing community placements under these circumstances, and already rejected the State's fundamental alteration defense. 1/29/99 Order.

Second, and relatedly, the federal government's (Br. 18-19) and the Eleventh Circuit's formulation (Pet. 22a-24a) of "deference to medical judgment" misapplies and undermines this important standard. The traditional purpose of deferring to medical judgment concerning State hospital care is to minimize "interference by the federal judiciary with the internal operations of the institutions," and to give deference to the presumptively valid decisions of expert administrators and medical professionals. *Youngberg v. Romeo*, 457 U.S. 307, 322 and n.29 (1982). But, in the Eleventh Circuit's and the government's view, professionals determine only if a patient "could" be placed in the community regardless of cost and other administrative considerations, an approach that will virtually always make hospitalization "unnecessary" and will virtually always insert the judiciary and DOJ into State placement decisions and ultimately the State's planning and budgeting process.

Finally, DOJ's new recognition of the impact of its reinterpretation of the integration regulation (Br. 25) underscores the fact that the interpretation itself requires a fundamental alteration of the State's system by requiring the closing of hospitals, increased transitional costs, full funding of the

existing demand for community placement for eligible individuals (estimated to cost \$100 million in State and federal funds—to serve 1,900 persons on the waiting list, J.A. 202) plus funding of an *indeterminate amount* of increased demand. Br. 21, 26. Although the government's new interpretation of the defense indeed allows a more thorough consideration of these impacts, it is hard to imagine how a litigation-driven standard that requires such changes is not a fundamental alteration of Georgia's system and potentially the health care systems of every other State. J.A. 201.

**12. The lower-court litigation history of § 504 does not support a least restrictive care interpretation of Title II A.** Plaintiffs concede that the Third and Seventh Circuits rejected a "least restrictive treatment" interpretation of § 504 prior to the enactment of the ADA. See *Clark v. Cohen*, 794 F.2d 79 (3rd Cir. 1985), *cert. denied*, 479 U.S. 962 (1986); *Phillips v. Thompson*, 715 F.2d 365 (7th Cir. 1983). And the United States' reference to the merest of dicta in *Kentucky Ass'n for Retarded Citizens, Inc. v. Conn*, 674 F.2d 582, 585 (6th Cir.) ("assuming arguendo" that § 504 could be interpreted to require treatment in the "least restrictive alternative"), *cert. denied*, 459 U.S. 1041 (1982), is not to the contrary. The other appellate decision announced in 1990, though admittedly shortly after the ADA was passed, nonetheless confirms the uniformity of the courts of appeals' decisions interpreting the Rehabilitation Act. *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. 1990). See also *Jackson v. Fort Stanton Hosp. & Training Sch.*, 964 F.2d 980 (10th Cir. 1992).

**13. Plaintiffs' rendition of the facts is misleading.** In this case, which was decided on summary judgment against the State by the Eleventh Circuit, plaintiffs inexplicably insert a lengthy and misleading set of facts. In response, we simply note the following undisputed facts as to L.C. (which are representative of both patients' treatment history) by way of providing a more complete context for this decision.

a. The State tried repeatedly to provide community-based care to L.C. before her most recent admission to GRH-A, the State hospital. Unfortunately, "[c]ommunity placement

failed over and over due to her threatening and violent behavior." R59, Ex. 13 at 2. On her most recent admission, L.C. was sent to GRH-A for evaluation after she threatened her community job supervisor with a knife. R59, Ex. 44 at 1. The job had been provided to her as an additional support while she lived in a community residential placement, an apartment with a full-time, one-on-one, live-in staff. R59, Ex. 13 at 4, 5. By the time the knife incident occurred, L.C. had lived there for not quite a year, and the May 1992 admission was her fifth emergency hospitalization during that time. *Id.*; R60, Amin dep. 87. After that admission, the community-placement provider notified the institution that it would not accept L.C. again. R59, Ex. 28 at 1.

b. Some of L.C.'s psychotic symptoms such as hallucinations were controlled early in this hospitalization. R60, Amin dep. 52; R60, Patel dep. 97-99. That rapid progress, however, was not matched by improvement in her disability-based behavior, which continued to be far from stable. R60, Amin dep. 84-85. She continued at times to fight and attack others without provocation, become verbally and physically intrusive during conversations with staff and other patients, scream, and urinate and disrobe inappropriately. R2, Exs. B ¶13, E-6 to E-8; R59, Ex. 13 at 2; R60, Amin dep. 49-50. Each of L.C.'s two successive treating psychiatrists concluded, based on her treatment history, that this aspect of her disability required improvement before community placement could be attempted again; otherwise they would simply be "setting her up for failure." R60, Amin dep. 63, 107; R59, Ex. 44 at 2; R60, Patel dep. 76-77, 88. This improvement did occur with treatment but not until April or May 1995, just before her trial release and subsequent discharge. R60, Amin dep. 58-59; R60, Patel dep. 88, 91-92, 97-99; R61, Ex. A ¶5.

c. As L.C.'s condition improved, she could and at various times did in fact leave the hospital and receive a wide variety of community-care services while at times living outside the hospital and while at other times living at the hospital and leaving it during the day. She began to leave the institution in August 1994, via public transportation for persons with disabilities, to attend a daily community-based



program that included social activities, vocational opportunities, and field trips; L.C. returned on the bus each evening to the institution. R2, Ex. F.

d. It became clear over time that, because of L.C.'s chronic and serious disabilities, a community placement for her would have to offer an unusually high level of support, including 24-hour supervision, medication monitoring, assistance with activities of daily living, structured day activities, and vocational-rehabilitation, mental-health, and mental-retardation services. R59, Ex. 13; R60, Amin dep. 61, 69-70; R60, Patel dep. 101. At the specific time that she first became ready for placement, all of Georgia's matching funds for Medicaid waivers were already being used to provide community placements for other disabled persons. *See* J.A. 135-140. Consequently, GRH-A in May 1995 arranged an extended monitored trial visit by L.C. to her mother's home. Later, in February 1996, when funds became available, L.C. was placed in a highly structured community placement. Pet. 2a, n.2.

**14. Plaintiffs' policy-based arguments are inaccurate and unpersuasive.** In light of plaintiffs' inflammatory references to eugenics, racial segregation and other inapt charges, it asks too much of Georgia not to respond. Because such unfair generalizations have "wounding stigmas" of their own, let us say the following.

First, since 1978, separate and apart from the Medicaid waiver program, Georgia on its own initiative has required the "least restrictive alternative placement" within the limits of funds appropriated for such care. O.C.G.A. §§ 37-3-161, 37-3-1(10) (1995). Between 1992 and 1997, the number of persons funded in Medicaid waiver community placements in Georgia increased from 283 to 1,938 (significantly more than the 700 that the Department identified, U.S. Br. 21); 500 State hospital beds were eliminated system-wide and two large State institutions were closed (significantly more than the 237 beds that the plaintiffs identified, Br. 5); hospital admissions declined 30 percent; patient-days of hospital care declined 19 percent; and the percentage of community funding increased

from 51 percent to 57 percent of the combined community and institutional funding. J.A. 199-201.

Nor is it appropriate to suggest that Georgia should simply purchase more of these community residences, which plaintiffs claim are less expensive than providing care in a hospital, so that all of its disabled citizens may live in publicly funded residences rather than in State-run hospitals. As the federal government itself has recognized, when a State begins offering a residence with 24-hour supervision to individuals in need of psychiatric care at no extra cost to the individual, the demand for this benefit will predictably increase. U.S. Br. 21; GENERAL ACCOUNTING OFFICE/HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, *SUCCESSFUL STATE EFFORTS TO EXPAND HOME SERVICES WHILE LIMITING COSTS* 4 (Aug. 1994). This expanded demand makes it difficult simply to assume that, all things being equal, an unlimited supply of hospital-based care will cost less than an unlimited supply of community-care residences. *Id.*

As the facts of this case well illustrate, moreover, a State must frequently ensure that it has available both hospital-care beds and community-based-care beds for the same individual. Both plaintiffs in this case have historically been in and out of State hospitals on an involuntary basis, and there can be no assurance that even the best community-based care will guarantee that the State will never need involuntarily to commit such an individual again. Moving an individual into a community-based program, in short, does not mean that the State no longer needs to have available a hospital bed in the event they need such care in the future. For this reason, States face

serious risks with erring on the side of providing too few rather than too many State hospital beds.

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No. 98-536

**In the Supreme Court of the United States**

CLERK

OCTOBER TERM, 1998

TOMMY OLMSTEAD, COMMISSIONER,  
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*v.*

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AND NEXT FRIEND, ET AL.

ON WRIT OF CERTIORARI  
TO THE UNITED STATES COURT OF APPEALS  
FOR THE ELEVENTH CIRCUIT

**BRIEF FOR THE UNITED STATES  
AS AMICUS CURIAE SUPPORTING RESPONDENTS**

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## QUESTION PRESENTED

Title II-A of the Americans With Disabilities Act of 1990 (ADA), 42 U.S.C. 12132, provides that "no qualified individual with a disability shall, by reason of such disability, \* \* \* be subjected to discrimination by any [public] entity." The Attorney General's "integration regulation," 28 C.F.R. 35.130(d), provides that "a public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The Attorney General interprets that regulation to require a State that offers treatment to persons with disabilities to provide such treatment in a community setting that offers opportunities for interaction with persons without disabilities, rather than in an institution, when (1) the State's treatment professionals have determined, in the exercise of reasonable professional judgment, that community placement of the individual is appropriate, and (2) such a placement would not require an unreasonable change in state policy or a fundamental alteration in the nature of the State's treatment program. The question presented is whether the regulation as so interpreted validly implements the ADA.



## TABLE OF CONTENTS

|   | Page |
|---|------|
| Interest of the United States .....   | 1    |
| Statement .....   | 2    |
| Summary of argument .....   | 5    |
| Argument:   |      |
| The Attorney General reasonably interpreted the integration regulation to prohibit the unjustified segregation of persons in institutions, and the regulation as so construed falls within the Attorney General's authority to implement Title II ..... | 7    |
| A. The Attorney General has reasonably interpreted the integration regulation to prohibit the unjustified segregation of persons in institutions .....  | 9    |
| B. The Attorney General was warranted in concluding that the unjustified segregation of persons in institutions constitutes a form of discrimination based on disability prohibited by Title II .....   | 11   |
| C. The integration regulation does not intrude on the professional judgment of state treatment professionals and does not impose undue costs on the states .....  | 18   |
| D. Petitioners' remaining arguments are unpersuasive .....  | 23   |
| Conclusion .....  | 30   |
| Appendix .....  | 1a   |

## TABLE OF AUTHORITIES

### Cases:

|  |        |
|--|--------|
| <i>Alexander v. Choate</i> , 469 U.S. 287 (1985) .....                   | 12, 25 |
| <i>Auer v. Robbins</i> , 519 U.S. 452 (1997) .....                       | 10     |
| <i>Bragdon v. Abbott</i> , 118 S. Ct. 2196 (1998) .....                  | 11, 23 |
| <i>Central Bank v. First Interstate Bank</i> , 511 U.S. 164 (1994) ..... | 26     |

## IV

| Cases—Continued:  | Page       |
|---|------------|
| <i>Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.</i> , 467 U.S. 837 (1984) .....   | 11         |
| <i>City of Boerne v. Flores</i> , 521 U.S. 507 (1997) .....   | 29         |
| <i>City of Cleburne v. Cleburne Living Ctr.</i> , 473 U.S. 432 (1985) .....   | 29         |
| <i>City of Edmonds v. Oxford House, Inc.</i> , 514 U.S. 725 (1995) .....  | 27         |
| <i>Fidelity Fed. Sav. &amp; Loan Ass'n v. de la Cuesta</i> , 458 U.S. 141 (1982) .....  | 28         |
| <i>Garrity v. Gallen</i> , 522 F. Supp. 171 (D.N.H. 1981) .....   | 24         |
| <i>Gregory v. Ashcroft</i> , 501 U.S. 452 (1991) .....  | 26, 27, 28 |
| <i>Guardians Ass'n v. Civil Serv. Comm'n</i> , 463 U.S. 582 (1983) .....  | 12         |
| <i>Halderman v. Pennhurst State Sch. &amp; Hosp.</i> , 446 F. Supp. 1295 (E.D. Pa. 1978), aff'd in part and rev'd in part, 612 F.2d 84 (3d Cir. 1979), rev'd, 451 U.S. 1 (1981) ..... | 24         |
| <i>Helen L. v. DiDario</i> , 46 F.3d 325 (3d Cir.), cert. denied, 516 U.S. 813 (1995) .....   | 10         |
| <i>Homeward Bound, Inc. v. Hissom Mem'l Ctr.</i> , No. 85-C-437-E, 1987 WL 27104 (N.D. Okla. July 24, 1987) .....   | 24         |
| <i>Jackson v. Fort Stanton Hosp. &amp; Training Sch.</i> , 757 F. Supp. 1243 (D.N.M. 1990), rev'd on other grounds, 964 F.2d 980 (10th Cir. 1992) .....                               | 24         |
| <i>Katzenbach v. Morgan</i> , 384 U.S. 641 (1966) .....   | 30         |
| <i>Kentucky Ass'n for Retarded Citizens, Inc. v. Conn</i> , 674 F.2d 582 (6th Cir.), cert. denied, 459 U.S. 1041 (1982) .....   | 24         |
| <i>Lynch v. Maher</i> , 507 F. Supp. 1268 (D. Conn. 1981) .....   | 24         |
| <i>P.C. v. McLaughlin</i> , 913 F.2d 1033 (2d Cir. 1990) .....  | 24         |
| <i>Pennhurst State Sch. &amp; Hosp. v. Halderman</i> , 451 U.S. 1 (1981) .....  | 28, 29     |

## V

| Cases—Continued:   | Page                 |
|--|----------------------|
| <i>Pennsylvania Dep't of Corrections v. Yeskey</i> , 118 S. Ct. 1952 (1998) .....  | 10                   |
| <i>People First v. Arlington Dev. Ctr.</i> , 878 F. Supp. 97 (W.D. Tenn. 1992) .....   | 24                   |
| <i>Regents of the Univ. of Cal. v. Bakke</i> , 438 U.S. 265 (1978) .....   | 12                   |
| <i>S.H. v. Edwards</i> , No. C81-877A (N.D. Ga. Apr. 10, 1987), aff'd, 860 F.2d 1045 (11th Cir. 1988), cert. denied, 491 U.S. 905 (1989) ..... | 24                   |
| <i>Salinas v. United States</i> , 522 U.S. 52 (1997) .....   | 27, 29               |
| <i>School Bd. v. Arline</i> , 480 U.S. 273 (1987) .....  | 9, 19, 25, 29        |
| <i>Southeastern Community College v. Davis</i> , 442 U.S. 397 (1979) .....   | 12, 25               |
| <i>Thomas Jefferson Univ. v. Shalala</i> , 512 U.S. 504 (1994) .....   | 9, 10                |
| <i>Traynor v. Turnage</i> , 485 U.S. 535 (1988) .....  | 24, 25               |
| <i>Youngberg v. Romeo</i> , 457 U.S. 307 (1982) .....  | 9, 19                |
| Constitution, statutes and regulations:  |                      |
| U.S. Const. Amend. XIV, § 5 .....  | 29, 30               |
| Age Discrimination in Employment Act of 1967, 29 U.S.C. 621 <i>et seq.</i> .....   | 26                   |
| Americans with Disabilities Act of 1990, 42 U.S.C. 12101 <i>et seq.</i> :  |                      |
| 42 U.S.C. 12101(a)(2) .....  | 12, 13, 30, 1a       |
| 42 U.S.C. 12101(a)(3) .....  | 4, 6, 12, 13, 30, 1a |
| 42 U.S.C. 12101(a)(5) .....  | 4, 6, 12, 18, 30, 1a |
| 42 U.S.C. 12101(a)(7) .....  | 18, 30               |
| 42 U.S.C. 12101(a)(8) .....  | 17-18, 1a            |
| 42 U.S.C. 12101(d) .....   | 26                   |
| Tit. I, 42 U.S.C. 12111 <i>et seq.</i> .....   | 7, 15                |
| 42 U.S.C. 12111(10)(A) .....   | 1a                   |
| 42 U.S.C. 12111(10)(B) .....   | 19, 1a               |
| 42 U.S.C. 12112 .....  | 7                    |
| Tit. II, 42 U.S.C. 12131 <i>et seq.</i> .....  | <i>passim</i>        |
| 42 U.S.C. 12132 .....  | 3, 7, 17, 28, 4a     |
| 42 U.S.C. 12133 .....  | 5a                   |



## VI

| Statutes and regulations—Continued:   | Page                             |
|---|----------------------------------|
| 42 U.S.C. 12134 .....   | 7-8, 27, 28, 5a                  |
| 42 U.S.C. 12134(a) .....  | 5a                               |
| 42 U.S.C. 12134(b) .....  | 14-15, 28, 5a                    |
| Tit. III, 42 U.S.C. 12181 <i>et seq.</i> .....  | 7, 15                            |
| 42 U.S.C. 12182(b) .....  | 7                                |
| 42 U.S.C. 12182(b)(1)(B) .....  | 15, 6a                           |
| Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. 6000 <i>et seq.</i> : |                                  |
| 42 U.S.C. 6001(10)(A) (Supp. II 1984) .....   | 16                               |
| 42 U.S.C. 6001(10)(B) (Supp. II 1984) .....   | 16                               |
| 42 U.S.C. 6001(15)(A) .....   | 16                               |
| 42 U.S.C. 6001(15)(B) .....   | 16                               |
| 42 U.S.C. 6001(15)(C) .....   | 16                               |
| 42 U.S.C. 6010(2) (1976) .....  | 28                               |
| Fair Housing Act, 42 U.S.C. 3601 <i>et seq.</i> .....   | 27                               |
| Individuals with Disabilities Education Act,  |                                  |
| 20 U.S.C. 1412(5)(B) .....  | 15-16                            |
| Medicare Act, 42 U.S.C. 1395 <i>et seq.</i> :   |                                  |
| 42 U.S.C. 1396d(b) .....  | 21                               |
| 42 U.S.C. 1396n(c) .....  | 20                               |
| Rehabilitation Act of 1973, § 504, 29 U.S.C. 794 .....  | 4, 6, 12, 15, 23, 24, 25, 28, 29 |
| Ga. Code Ann. § 37-4-121 (Mitchie 1995) .....   | 19                               |
| 28 C.F.R.:  |                                  |
| Pt. 35 .....  | 8                                |
| Section 35.130 .....  | 7a                               |
| Section 35.130(b)(7) .....  | 5, 7, 8, 19, 22, 10a             |
| Section 35.130(d) .....   | 3, 4, 5, 8, 19, 28, 10a          |
| Section 35.130(e)(1) .....  | 26, 11a                          |
| App. A, § 35.130 .....  | 8                                |
| Pt. 41:   |                                  |
| Section 41.51(d) (1997) .....   | 4                                |
| Section 41.51(d) .....  | 15                               |

## VII

| Miscellaneous:   | Page   |
|--|--------|
| 134 Cong. Rec. S5116 (daily ed. Apr. 28, 1988) .....   | 14     |
| 135 Cong. Rec. S4986 (daily ed. May 9, 1989) .....   | 14     |
| 136 Cong. Rec. H2447 (daily ed. May 17, 1990) .....  | 13-14  |
| 136 Cong. Rec. H2603 (daily ed. May 22, 1990) .....  | 17     |
| <i>Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Senate Comm. on Labor and Human Resources and the Subcomm. on the Handicapped</i> , 101st Cong., 1st Sess. (1989) .....      | 14     |
| H.R. Rep. No. 485, 101st Cong., 2d Sess., Pt. 3 (1990) .....   | 8      |
| Rosalie A. Kane et al., <i>The Heart of Long-Term Care</i> (1998) .....  | 21, 22 |
| <i>Oversight Hearing on H.R. 4498, Americans with Disabilities Act of 1988: Hearing Before the Subcomm. on Select Educ. of the House Comm. on Educ. and Labor</i> , 100th Cong., 2d Sess. (1988) ..... | 14     |
| S. Rep. No. 139, 97th Cong., 1st Sess. (1981) .....  | 20     |
| S. Rep. No. 273, 101st Cong., 2d Sess. (1990) .....  | 20     |
| U.S. Comm'n on Civil Rights, <i>Accommodating the Spectrum of Individual Abilities</i> (Clearinghouse Pub. No. 81, 1983) .....   | 13, 20 |
| William G. Weissert et al., <i>Cost Savings From Home And Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program</i> , 22 J. of Health Pol., Pol'y & L. 1329 (1997) .....       | 21, 22 |

**In the Supreme Court of the United States**

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*v.*

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*ON WRIT OF CERTIORARI  
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FOR THE ELEVENTH CIRCUIT*

---

**BRIEF FOR THE UNITED STATES  
AS AMICUS CURIAE SUPPORTING RESPONDENTS**

---

**INTEREST OF THE UNITED STATES**

The Attorney General has authority to enforce Title II of the Americans With Disabilities Act of 1990, 42 U.S.C. 12131 *et seq.* See 42 U.S.C. 12133. In addition to that enforcement responsibility, Congress has directed the Attorney General to issue regulations to set forth the forms of discrimination prohibited by Title II. 42 U.S.C. 12134(a). Pursuant to that mandate, the Attorney General has issued such regulations. See 28 C.F.R. Pt. 35. One of those regulations requires a public entity to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. 35.130(d). The Attorney General has interpreted that regulation to require the State, in some circumstances, to treat



persons with disabilities in a community setting rather than an institution. The validity of that interpretation is at issue here. The United States participated as an *amicus curiae* in this case in the court of appeals.

### STATEMENT

1. Respondents L.C. and E.W. are mentally retarded individuals who also have mental disorders. Pet. App. 32a-33a. Before the present litigation began, L.C. and E.W. were voluntary patients at the Georgia Regional Hospital at Atlanta (GRH-A) and were confined in a locked psychiatric unit. J.A. 2, 5, 45, 48, 62-63, 78-79. GRH-A is a large, state-run psychiatric institution whose programs are designed primarily to stabilize individuals during the acute phase of a mental illness so that treatment can be continued in the community on an outpatient basis. J.A. 13, 48-49.

L.C. was most recently admitted to GRH-A in May 1992. J.A. 14, 51. By May 1993, L.C.'s psychiatric condition had stabilized, and petitioners and L.C.'s treating physician agreed that she could appropriately be treated in a community setting. J.A. 5, 46, 120, 205-207. L.C. nonetheless remained at GRH-A until after the present litigation began in May 1995. In July 1995, petitioners discharged L.C. to a state-run institution for treatment of persons with mental retardation, and in February 1996, petitioners released L.C. to a community-based program. Pet. App. 33a.

E.W. was most recently admitted to GRH-A in February 1995. J.A. 64, 80. In March 1996, E.W.'s treating physician concluded that she could be appropriately treated in the community. J.A. 88-89, 210-212. In that same year, a clinical psychologist at GRH-A reached the same conclusion. J.A. 213-214; see also J.A. 101. E.W. nonetheless remained institutionalized until a few months after the district court issued

its judgment in 1997, at which point she was placed in a community-based program. Pet. App. 2a-3a n.2.

2. In 1995, L.C. filed suit against petitioners, alleging, *inter alia*, that petitioners had violated Title II of the ADA and its implementing regulations by failing to offer her treatment in a community-based residential program after treatment professionals determined that such a placement was appropriate. J.A. 26, 28; Pet. App. 31a. E.W. intervened, raising the same claim. J.A. 61-73. The district court granted summary judgment in part in favor of respondents. Pet. App. 31a-42a. The court held that petitioners' refusal to place respondents in a community-based program violated Title II of the ADA, which prohibits a public entity from subjecting any qualified individual with a disability to discrimination by reason of such disability, 42 U.S.C. 12132, as well as the Title II integration regulation, 28 C.F.R. 35.130(d), which requires a public entity to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Pet. App. 37a-39a. The court rejected petitioners' defense that they lacked funds to provide such placements to L.C. and E.W. *Id.* at 38a-39a.

3. The court of appeals affirmed the district court's judgment, but remanded for a reassessment of the State's cost-based defense. Pet. App. 1a-30a. The court held that when "a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting," unless such a placement would require a "fundamental alteration" in the State's treatment program. *Id.* at 21a-25a.

In reaching that conclusion, the court relied on the Attorney General's Title II integration regulation. The court concluded that "the plain language of § 35.130(d) prohibits a state from providing services to individuals with

disabilities in an unnecessarily segregated setting" and that a State violates that mandate when "the State confines an individual with a disability in an institutionalized setting when a community placement is appropriate." Pet. App. 7a, 8a.

The court rejected petitioners' contention that the integration regulation conflicts with the requirement in Title II that an individual must prove discrimination by reason of a disability. The court noted that Congress had instructed the Department of Justice to issue regulations that are consistent with the coordination regulations issued under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, and that one of those regulations requires integration in terms that are substantially the same as those in Section 35.130(d). Pet. App. 9a (citing 28 C.F.R. 41.51(d) (1997)). The court further concluded that the integration regulation was consistent with Congress's specific findings that Title II was intended to overcome discrimination in "institutionalization," and discrimination that takes the form of "segregation." *Id.* at 10a-11a (quoting 42 U.S.C. 12101(a)(3) and (5)). The court also determined that "the legislative history makes clear that Congress considered the provision of segregated services to individuals with disabilities a form of discrimination prohibited by the ADA." *Id.* at 11a. The court of appeals concluded that "because § 35.130(d) finds direct support in the plain language of the ADA, its congressional findings, and the Act's legislative history, we must apply it here." *Id.* at 12a.

The court held that, under Title II and its implementing regulations, a State's duty to provide integrated services when a patient's care warrants such services is not absolute. Pet. App. 25a. In reaching that conclusion, the court relied on the Attorney General's "reasonable-modification" regulation, which provides that "[a] public entity shall make reasonable modifications in policies, practices, or procedures

when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." Pet. App. 25a-26a (quoting 28 C.F.R. 35.130(b)(7)).

The court concluded that the key question was whether petitioners had shown that treating respondents in the community would cause a fundamental alteration in their program. Pet. App. 26a. Resolving that question, the court concluded, involves an assessment of several factors, including "whether treating [respondents] would require additional expenditures and if so, whether the State had met its burden of proving that those expenditures were unreasonable in light of the State's mental health budget." *Id.* at 28a. Because the district court had not addressed those questions, the court of appeals remanded for further proceedings. *Id.* at 29a-30a.<sup>1</sup>

### SUMMARY OF ARGUMENT

A. The Attorney General's Title II "integration regulation," 28 C.F.R. 35.130(d), provides that "[a] public entity shall administer services \* \* \* in the most integrated setting appropriate to the needs of qualified individuals with disabilities." By its terms, the integration regulation applies to all services administered by a public entity, including those that are offered exclusively to persons with disabilities. The Attorney General therefore interprets the regulation to require a State to provide services to persons

<sup>1</sup> Following this Court's grant of the petition for a writ of certiorari, the district court issued a decision on remand, rejecting petitioners' fundamental alteration defense. 1/29/99 Order at 1. The court found that the annual cost to the State of providing community-based treatment to L.C. and E.W.—about \$20,000 each—was not unreasonable in relation to the State's overall mental health budget, which was \$706.8 million in fiscal year 1998. *Id.* at 5.



with disabilities in a community setting, rather than in an institution, when a State's treatment professionals have determined, in the exercise of reasoned professional judgment, that community placement of the individual is appropriate. Because that interpretation accords with the text of the regulation, it is entitled to controlling weight.

B. The Attorney General was warranted in concluding that the unjustified segregation of persons in institutions, when community placement is appropriate, constitutes a form of discrimination prohibited by Title II. In the text of the ADA, Congress found that persons with disabilities suffer from various forms of discrimination, including "segregation," and that discrimination persists in several contexts, including "institutionalization," 42 U.S.C. 12101(a)(3) and (5). Those findings demonstrate that Congress understood the concept of discrimination under the ADA to include the unjustified segregation of disabled persons in institutions. Equally important, Congress instructed the Attorney General to adopt regulations that are consistent with coordination regulations that had been issued by the Department of Health, Education, and Welfare (HEW) to implement Section 504 of the Rehabilitation Act, 29 U.S.C. 794. One of HEW's coordination regulations required integration in substantially the same terms as the Attorney General's integration regulation. Congress therefore virtually mandated the integration regulation at issue here.

Congress had ample basis to conclude that the unjustified segregation of persons in institutions constitutes a form of discrimination based on disability. First, such segregation can stigmatize persons with disabilities as incapable or unworthy of participating in community life. Second, such segregation can result in a form of dissimilar treatment: Persons with disabilities must give up participation in community life in order to receive the services they need, while persons without disabilities can receive the services they

need without sacrificing that important interest. Finally, when persons with disabilities must obtain the services they need in an institution, they are effectively deprived of their right under the ADA to equal access to other public services.

C. The integration regulation does not impose undue costs on the State. By virtue of the Attorney General's "reasonable-modification" regulation, 28 C.F.R. 35.130(b)(7), the integration obligation does not apply when compliance would require an unreasonable change in state policy or a fundamental alteration in the nature of the State's treatment program. Costs have a bearing on those inquiries. Congress anticipated that the placement of persons in the community, rather than in an institution, would not impose undue costs. If a State can show that any additional costs of providing placement in a community setting are unreasonably high in comparison to a State's overall mental health budget, however, a State would not be required to provide placement in a community setting.

### ARGUMENT

#### **THE ATTORNEY GENERAL REASONABLY INTERPRETED THE INTEGRATION REGULATION TO PROHIBIT THE UNJUSTIFIED SEGREGATION OF PERSONS IN INSTITUTIONS, AND THE REGULATION AS SO CONSTRUED FALLS WITHIN THE ATTORNEY GENERAL'S AUTHORITY TO IMPLEMENT TITLE II**

Title II, Part A of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. 12132. Unlike Titles I and III of the Act, Title II-A does not spell out the forms of discrimination that are prohibited. Compare 42 U.S.C. 12112 and 42 U.S.C. 12182(b). Instead, Congress directed that "the Attorney General shall pro-

mulgate regulations in an accessible format that implement this part." 42 U.S.C. 12134. That Section required the Attorney General "to issue regulations setting forth the forms of discrimination prohibited." H.R. Rep. No. 485, 101st Cong., 2d Sess., Pt. 3, at 52 (1990).

The Attorney General issued regulations in 1991. 28 C.F.R. Pt. 35. One of those regulations, the integration regulation, provides that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. 35.130(d). In the preamble to the regulations, the Attorney General explained that "the most integrated setting" is "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. Pt. 35 App. A § 35.130, at 469 (1996).

The obligation set forth in the integration regulation is not absolute. When compliance would require a change in state policy, the integration obligation is subject to the reasonable-modification standard set forth in 28 C.F.R. 35.130(b)(7). That regulation provides that "[a] public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." Thus, a State must provide services to a person with a disability in an integrated setting when appropriate to that person's needs, unless it would require an unreasonable change in state policy or fundamentally alter the program.

Consistent with its text, the Attorney General interprets the integration regulation to require States, in certain circumstances, to place persons with disabilities in a community setting that offers opportunities for interaction with persons without disabilities, rather than in an institution, where such

opportunities are far more limited, if they exist at all. In particular, when state treatment professionals determine, in the exercise of reasoned professional judgment, that placement in a community setting is appropriate (*Youngberg v. Romeo*, 457 U.S. 307, 323 (1982); see also *School Bd. v. Arline*, 480 U.S. 273, 288 (1987)), and such a placement would not require an unreasonable change in state policy or a fundamental change in the State's treatment program, a State must offer the individual an opportunity for placement in a community setting.

Petitioners challenge the Attorney General's interpretation of the integration regulation on two grounds. First, they argue that it reflects an impermissible reading of the regulation itself. Second, they argue that it exceeds the Attorney General's authority to define the forms of discrimination that are prohibited by Title II. As we demonstrate below, both arguments are without merit.

**A. The Attorney General Has Reasonably Interpreted The Integration Regulation To Prohibit The Unjustified Segregation Of Persons In Institutions**

Petitioners contend (Br. 41-42) that the integration regulation applies only to services that a State provides to non-disabled persons. That limitation, however, cannot be found in the text of the regulation. The regulation facially applies to *all* services administered by a public entity, including those that are offered only to persons with disabilities. Under this Court's decisions, an agency's interpretation of its own regulations is "controlling," unless it is "plainly erroneous" or "inconsistent with the regulation." *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994). Because the Attorney General's interpretation accords with the plain language of the regulation, that deferential standard is satisfied.



Petitioners incorrectly assert (Br. 41-42) that the Attorney General originally interpreted the integration regulation to apply only to those services that are offered to non-disabled persons. As petitioners note (Br. 41), the Attorney General has stated that requiring a disabled person to eat in the back of a government cafeteria, or requiring a blind person to go on a special museum tour rather than on the tour that is offered to the general public would violate the integration regulation. See also Pet. Br. App. 18a-20a. But the Attorney General never intimated that those are the only contexts in which the integration regulation applies. When an agency adopts a regulation, it has no obligation to list all conceivable examples of the contexts in which the rule will apply. Indeed, such a requirement would be completely unworkable. See *Pennsylvania Dep't of Corrections v. Yeskey*, 118 S. Ct. 1952, 1955-1956 (1998). Petitioners therefore err in treating the particular examples discussed by the Attorney General as a limitation on the terms of the regulation. See *Thomas Jefferson Univ.*, 512 U.S. at 516.

Nor is there any merit to petitioners' suggestion (Br. 41-42) that the Attorney General's interpretation of the regulation is not entitled to deference because it was publicly articulated for the first time in a brief filed in *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir.), cert. denied, 516 U.S. 813 (1995). This Court rejected a similar contention in *Auer v. Robbins*, 519 U.S. 452 (1997). There, the Court deferred to an agency's interpretation of its own regulation that appeared for the first time in a brief submitted to the Court. *Id.* at 462-463. The Court explained that the Secretary's position was not "a post-hoc rationalization advanced by an agency seeking to defend past agency action against attack," and that there was "simply no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question." *Id.* at 462.

Those requirements for deference are satisfied here. The Department of Justice brief in *Helen L.* was not a post-hoc effort to defend a previous agency action, but was instead a fair and considered judgment on the issue.

Thus, as the court of appeals concluded (Pet. App. 8a), the "express terms of § 35.130(d), supported by the Attorney General's consistent interpretation, plainly prohibit a state from treating individuals with disabilities in a segregated environment, where a more integrated setting would be appropriate."

**B. The Attorney General Was Warranted In Concluding That The Unjustified Segregation Of Persons In Institutions Constitutes A Form Of Discrimination Based On Disability Prohibited By Title II**

Because the Attorney General issued the integration regulation pursuant to an express grant of authority to give content to the general statutory prohibition against discrimination, it is entitled to "controlling weight," unless it is "arbitrary, capricious, or manifestly contrary to the statute." *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984). This Court has also held that, "[a]s the agency directed by Congress to issue implementing regulations, \* \* \* to render technical assistance explaining the responsibilities of covered individuals and institutions, \* \* \* and to enforce [the ADA] in court, \* \* \* the Department's views are entitled to deference." *Bragdon v. Abbott*, 118 S. Ct. 2196, 2209 (1998).

Petitioners contend that the Attorney General acted outside the permissible limits of her authority to implement Title II. In particular, they argue (Br. 21) that Title II's prohibition on "discrimination" based on disability requires proof that similarly situated persons have been treated differently, and that, when a State offers a service only to persons with disabilities, such a showing of dissimilar

treatment cannot be made. The term "discrimination," however, does not have a single meaning; its meaning therefore must be derived from the statutory context in which it appears. See *Alexander v. Choate*, 469 U.S. 287 (1985) (Section 504 ban on discrimination reaches practices that have the effect of denying meaningful access to persons with disabilities); *Southeastern Community College v. Davis*, 442 U.S. 397, 413 (1979) (refusal to make a reasonable modification to accommodate persons with disabilities constitutes discrimination under Section 504); *Guardians Ass'n v. Civil Serv. Comm'n*, 463 U.S. 582, 592 (1983) (White, J.) (the term "discrimination" is "inherently" ambiguous); *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265, 284 (1978) (Powell, J.) (the concept of discrimination "is susceptible of varying interpretations"). The Attorney General was warranted in concluding that, in the context of the ADA, "discrimination" based on disability includes the unjustified segregation of a disabled person in an institution.

1. a. That statutory context includes the specific findings that Congress enacted as part of the ADA. Among other things, Congress found that "historically, society has tended to isolate and segregate individuals with disabilities, and \* \* \* such forms of discrimination \* \* \* continue to be a serious and pervasive social problem." 42 U.S.C. 12101(a)(2). It found that "individuals with disabilities continually encounter various forms of discrimination, including \* \* \* segregation." 42 U.S.C. 12101(a)(5). And it found that such discrimination persists in a variety of contexts, including "institutionalization." 42 U.S.C. 12101(a)(3). Those findings make clear that Congress understood the concept of discrimination under the ADA to include the unjustified segregation of disabled persons in institutions.

b. The genesis of Congress's findings supports that conclusion. The relevant findings were drawn from the almost-

identical findings made by the U.S. Commission on Civil Rights in a report entitled *Accommodating the Spectrum of Individual Abilities* (Clearing House Pub. No. 81, 1983). Compare *id.* at 159 with 42 U.S.C. 12101(a)(2) and (3)). One section of the report includes "institutionalization" among the areas in which discrimination against persons with disabilities occurs. *Accommodating the Spectrum of Individual Abilities*, *supra*, at 32-34. The report observed that "[i]nstitutionalization almost by definition entails segregation and isolation." *Ibid.* The report further noted that, while "there has been increasing acceptance in recent years of the fact that most training, treatment, and habilitation services can be better provided to handicapped people in small, community-based facilities rather than in large, isolated institutions, \* \* \* a great many handicapped persons remain in segregative facilities." *Id.* at 34-35.

Another section of the report identifies "segregation" as a form of discrimination based on disability, explaining that "[s]egregation singles out handicapped people and separates them from the rest of society, frequently as a condition for receiving some service or benefit." *Accommodating the Spectrum of Individual Abilities*, *supra*, at 41. The report further states that "[m]ental health and mental retardation institutions that house residents in almost complete isolation from the non-handicapped community are perhaps archetypal examples of segregation." *Ibid.*

c. The legislative debates and hearings confirm that Congress's findings concerning "segregation" and "institutionalization" reflect an understanding that the unjustified segregation of persons with disabilities in institutions constitutes a form of disability-based discrimination. Numerous statements attest to that understanding. *E.g.*, 136 Cong. Rec. H2447 (daily ed. May 17, 1990) (statement of Rep. Miller) ("[I]t has been our unwillingness to see all people with disabilities that has been the greatest barrier to full and



meaningful equality. Society has made them invisible by shutting them away in segregated facilities.”); 134 Cong. Rec. S5116 (daily ed. Apr. 28, 1988) (statement of Sen. Simon) (persons with disabilities “remain[] substantially hidden. They are hidden in institutions. They are hidden in nursing homes. \* \* \* Because they are hidden, we too easily ignore the problem and the need for change.”); 135 Cong. Rec. S4986 (daily ed. May 9, 1989) (statement of Sen. Harkin) (a purpose of the ADA is get disabled persons “out of institutions”); *Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Senate Comm. on Labor and Human Resources and the Subcomm. on the Handicapped*, 101st Cong., 1st Sess. 215 (1989) (statement of former Senator Weicker) (“For years, this country has maintained a public policy of protectionism toward people with disabilities. We have created monoliths of isolated care in institutions and in segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal.”); *Oversight Hearing on H.R. 4498, Americans with Disabilities Act of 1988 Before the Subcomm. on Select Educ. of the House Comm. on Educ. and Labor*, 100th Cong., 2d Sess. 193 (1988) (statement of Phillip Campbell, Ass’n for Retarded Citizens of Mass.) (“Persons with mental retardation have experienced some of the grossest examples of discrimination during the last 100 years. They have been relegated to segregated congregate facilities across the Nation.”).

2. Congress’s understanding that Title II would prohibit the unjustified segregation of persons in institutions is also reflected in its express instruction to the Attorney General to promulgate regulations consistent with (1) existing regulations under a related statute, and (2) the definitions of discrimination that appear in other titles of the ADA. Congress specified, 42 U.S.C. 12134(b), that, “[e]xcept for

‘program accessibility, existing facilities’, and ‘communications’, regulations under subsection (a) of this section shall be consistent with this chapter and with the coordination regulations under part 41 of title 28, Code of Federal Regulations (as promulgated by the Department of Health, Education, and Welfare [HEW] on January 13, 1978), applicable to recipients of Federal financial assistance under section 794 of title 29 [Section 504 of the Rehabilitation Act].” That language requires the Attorney General, in issuing regulations to enforce Title II, to make the regulations consistent with other parts of “this chapter”, i.e., Titles I (employment) and III (public accommodations) of the ADA, and with the coordination regulations that had been issued by HEW to enforce Section 504 of the Rehabilitation Act.

In adopting the integration regulation, the Attorney General adhered to that mandate. The integration regulation tracks a Section 504 coordination regulation that provides that “[r]ecipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.” 28 C.F.R. 41.51(d). The integration regulation also parallels a requirement in Title III of the ADA, which provides that “[g]oods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.” 42 U.S.C. 12182(b)(1)(B). By requiring the Attorney General to adopt regulations “consistent” with the HEW coordination regulations and with the ADA, Congress virtually mandated the integration regulation at issue here.<sup>2</sup>

<sup>2</sup> Congress expressed the same integration mandate in the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1412(5)(B), requiring States that receive federal funds under that statute to “assure that, to the

Moreover, like the Attorney General's integration regulation, HEW's comparable coordination regulation and the requirement in Title III are not, by their terms, limited to those services that are offered to persons without disabilities; instead, they apply to all services that are offered. Nor is there any reason to believe that Congress understood the regulation or the statutory provision to contain an implicit limitation not found in the text. To the contrary, in a 1984 statute Congress had previously used the term "integration" in regard to individuals with developmental disabilities, and defined it to include not only the opportunity for persons with disabilities to use the same services and participate in the same activities as non-disabled persons, 42 U.S.C. 6001(10)(A) (Supp. II 1984), now codified at 42 U.S.C. 6001(15)(A) and (C), but also "the residence by persons with developmental disabilities in homes or home-like settings which are in proximity to community resources, together with regular contact with nonhandicapped citizens in their communities." 42 U.S.C. 6001(10)(B) (Supp. II 1984), now codified at 42 U.S.C. 6001(15)(B). In light of Congress's mandate to formulate an integration regulation, and Congress's understanding of that term, the Attorney General was warranted in concluding that Congress viewed a State's unjustified decision to place a disabled person in an institution, rather than in a community setting, as a form of discrimination based on disability.

3. Congress had ample basis to conclude that such a decision constitutes discrimination based on disability. Segregating persons with disabilities into institutions when they can be appropriately placed in community settings can have several distinct discriminatory effects. First, the unjustified segregation of persons with disabilities can stigmatize them

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maximum extent appropriate, children with disabilities \* \* \* are educated with children who are not disabled."

as incapable or unworthy of participating in community life. See 136 Cong. Rec. H2603 (daily ed. May 22, 1990) (statement of Rep. Collins) ("To be segregated is to be misunderstood, even feared," and "only by breaking down barriers between people can we dispel the negative attitudes and myths that are the main currency of oppression."). Segregation always has the potential to engender or perpetuate negative attitudes, and when the segregation is unnecessary for treatment purposes, it is especially likely to result from and reinforce negative attitudes.

Second, the unjustified segregation of persons with disabilities into institutions imposes a substantial burden on persons with disabilities that the State does not impose on persons without disabilities: In order to obtain the medical or therapeutic services that they need, persons with disabilities must sacrifice their interest in community life, while persons without disabilities can obtain the services from the State that they need without sacrificing that important interest.

Finally, the unjustified segregation of persons with disabilities into institutions can defeat the statutory requirement—not disputed by petitioners—that the State make available to persons with disabilities the *same* services that they provide to non-disabled persons. 42 U.S.C. 12132. When persons with disabilities must obtain the services they need in an institution, rather than in a community setting, they are effectively deprived of equal access to parks, beaches, museums, and other similar public services.

4. The integration regulation's prohibition against unjustified segregation of persons in institutions is well-designed to serve the important goals that Congress sought to further through enactment of the ADA. In the text of the Act, Congress stated that its goals "regarding individuals with disabilities" were to "assure" not only "equality of opportunity," but also "full participation, independent living,



and economic self-sufficiency for such individuals." 42 U.S.C. 12101(a)(8). The Attorney General's integration regulation serves all those purposes, while petitioners' interpretation of Title II does not.

Indeed, as Congress knew, the isolation of persons with disabilities can breed fear and stereotypes about persons with disabilities, which in turn can generate additional discrimination that spills over into other areas, such as employment, public accommodations, and transportation. See 42 U.S.C. 12101(a)(5) (finding persistent discrimination in those areas); 42 U.S.C. 12101(a)(7) (finding that persons with disabilities face discrimination as a result of "stereotypic assumptions"). The Attorney General properly recognized, as did Congress, that this cycle of discrimination could perpetuate itself indefinitely unless efforts were taken to increase interaction between persons with disabilities and non-disabled persons. The integration regulation promotes such interaction and thereby helps to erode the negative stereotypes that continue to impede equality of opportunity. Prohibiting unjustified segregation of persons in institutions thus goes hand-in-hand with all the other portions of the ADA, including the barrier-removal obligations, the reasonable-accommodation requirements, and the prohibitions on denial of equal benefits and services. All those provisions promote the common objective of integrating persons with disabilities into the mainstream of society.

**C. The Integration Regulation Does Not Intrude On The Professional Judgment Of State Treatment Professionals And Does Not Impose Undue Costs On The States**

1. Petitioners mistakenly assert (Br. 38) that the integration regulation intrudes on the treatment decisions of the State's health professionals. The integration regulation does not require a State to provide a community placement when

the State's treatment professionals determine that such a placement is not "appropriate," and that determination is based on a reasonable professional judgment that is not affected by extraneous considerations such as administrative convenience and costs. 28 C.F.R. 35.130(d); see *Youngberg*, 457 U.S. at 323; *Arline*, 480 U.S. at 288. Petitioners' complaint that the integration regulation interferes with state treatment policy has a particularly hollow ring in this case, since the State's own treatment professionals determined that the placement of respondents in a community setting would be appropriate. See p. 2, *supra*. And Georgia law expresses a preference for treatment in the most integrated environment appropriate. Ga. Code Ann. § 37-4-121 (Mitchie 1995) ("It is the policy of the state that the least restrictive alternative placement be secured for every client at every stage of his habilitation. It shall be the duty of the facility to assist the client in securing placement in noninstitutional community facilities and programs.").

2. Petitioners are similarly mistaken in their assertion (Br. 13) that the integration regulation imposes "massive" costs on the States. As we have noted, the integration mandate does not apply when compliance would require an unreasonable change in state policy or a fundamental alteration in the nature of the State's treatment program. 28 C.F.R. 35.130(b)(7). Costs have a bearing on those inquiries. As the court of appeals concluded (Pet. App. 28a), if any additional costs of providing treatment in a community setting, rather than an institution, were shown to be unreasonable in comparison to a State's overall mental health budget, a State would not be required to provide the treatment in a community setting. Cf. 42 U.S.C. 12111(10) (B) (factors for determining undue hardship under Title I

include cost and overall financial resources of the covered entity).<sup>3</sup>

Unsubstantiated claims of such costs, however, are no substitute for proof. Congress has found that community placements are less expensive, on average, than institutional care, S. Rep. No. 139, 97th Cong., 1st Sess. 481 (1981); S. Rep. No. 273, 101st Cong., 2d Sess. 7, 25-26 (1990), and numerous studies have reached the same conclusion. *Accommodating the Spectrum of Individual Abilities*, *supra*, at 78 ("Virtually all the relevant literature documents that segregating handicapped people in large, impersonal institutions is the most expensive means of care."). Petitioners also acknowledge (J.A. 84-85, 171) that community-based care of mentally retarded persons is generally less expensive, on a per-patient basis, than institutional care. For example, Georgia has estimated (J.A. 171) that it would cost \$30,000 to \$60,000 more per person per year to keep mentally retarded individuals in an institution than it would cost to move them to a community program and provide necessary support services.

Moreover, in 1981, Congress enacted a Medicaid "waiver" program that permits States to apply to the Department of Health and Human Services (HHS) for a waiver of certain Medicaid rules in order to offer community-based services. See 42 U.S.C. 1396n(c). Under the program, the federal government provides between 50% and 83% of the total Medicaid costs for community-based care, the same federal

<sup>3</sup> It would also be a fundamental alteration to require a State to create an entirely new community-based program. For example, a State that has a community-based program that serves persons with mental retardation would not be required to create a program to serve mentally ill individuals who are not mentally retarded. A State, however, could be required to expand existing community-based programs to serve additional eligible individuals to the extent that such an expansion did not require an unreasonable change in state policy or a fundamental alteration.

contribution that is available for institutional care. 42 U.S.C. 1396d(b). By 1996, HHS had authorized (at Georgia's request) matching funds for up to 2109 community placements. Georgia, however, used only 700 of its "waiver slots." J.A. 93. When petitioners ultimately moved respondents to community placements, they used federal money from the waiver program to offset a significant portion of the cost of such care. J.A. 161-164.

At the same time, the federal government's experience in operating the Medicaid waiver program has revealed costs that States may incur in the aggregate in moving persons from institutions to more integrated settings. If a State is unable to close or consolidate facilities, it may experience increased overall expenses by funding community placements without being able to take advantage of the savings associated with the closure of institutions. If a State is able to consolidate or close facilities in response to community placements, the State may still incur the transitional cost of operating institutions that are only partially full until the closure or consolidation can be completed. The fixed overhead costs involved in operating those facilities may negate the cost savings that States could otherwise achieve by treating persons in the community rather than in institutions. See Pet. App. 28a-29a; J.A. 171-172. The availability of community placements may also increase the aggregate demand for community services among those not currently in institutions. For example, persons eligible for treatment may not have sought it in the past because they were unwilling to receive it in an institution. The increased availability of community services may prompt such persons to seek treatment for the first time. See William G. Weissert et al., *Cost Savings From Home And Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program*, 22 J. of Health Pol., Pol'y & L. 1329, 1337-1339, 1344 (1997); Rosalie A. Kane et al., *The Heart Of Long-Term Care* (1998).



Nonetheless, studies dealing with the elderly suggest that those concerns can be anticipated and that it appears possible to design a community placement program that manages costs and need not produce unreasonable increases in the overall cost to the State of providing long-term care. Weissert, *supra*, 22 J. of Health Pol., Pol'y & L. at 1343, 1345-1347; Kane, *supra*, at 70-71.

In addition, nothing in the ADA suggests that courts must ignore the States' legitimate administrative concerns in accomplishing the transition of eligible individuals from institutional to community-based care. The transfer of eligible persons from institutions to the community is a multifaceted process that sometimes cannot be accomplished all at once. Even when treating professionals have evaluated eligible individuals and determined that a community setting is appropriate, States will need to locate proper community placements and determine which eligible individuals should receive priority for available slots. In order to ensure that this occurs in an orderly fashion, States may appropriately adopt a plan that addresses various administrative issues, including the order in which eligible persons will be placed in the community, so as to proceed in a systematic and prompt way. In determining whether a public entity has a defense under 28 C.F.R. 35.130(b)(7), a court may appropriately take into account whether the public entity has adopted such a plan to achieve compliance with the ADA. If a State establishes that it has such a plan, that plan would serve as a valid defense in situations where a particular request for a community placement was inconsistent with the plan and responding to such a request and similar requests would so disrupt the orderly implementation of the plan as to create an unreasonable change in state policy or a fundamental alteration not required by the ADA.

Petitioners conceded below (J.A. 159) that the costs of providing services to respondents in the community "are, by

definition, not unreasonable, nor could they 'fundamentally alter' the services provided by the State." Petitioners contend, however, that the relevant inquiry is the cost of providing services to all persons who desire it and that the court of appeals erred in limiting the inquiry to the costs of providing treatment to respondents. Br. 37-38. In their question presented to this Court, petitioners did not challenge the court of appeals' ruling on that ground. In any event, the court of appeals did not preclude petitioners from introducing evidence that they had devised a comprehensive plan that takes into account the aggregate costs of moving persons from institutions to community settings, and that placement of respondents would fundamentally alter that plan. While the court of appeals instructed the district court to consider the costs of providing services to the respondents, it also stated that "[t]he district court may also consider any other factors it believes are relevant to the fundamental alteration inquiry." Pet. App. 30a.

#### **D. Petitioners' Remaining Arguments Are Unpersuasive**

Petitioners offer a series of additional arguments intended to show that the Attorney General's integration regulation exceeds the authority conferred by Congress to implement the Title II mandate against discrimination based on disability. None is persuasive.

1. Petitioners first contend (Br. 22-29) that, prior to enactment of the ADA, courts uniformly rejected claims that Section 504 required placement of persons with disabilities in the community. Petitioners further contend that Congress intended to incorporate that settled interpretation when it enacted the ADA. See *Bragdon*, 118 S. Ct. at 2208. The premise of petitioners' argument is incorrect: prior to enactment of the ADA, there was no settled judicial understanding concerning whether Section 504 prohibited the

unjustified segregation of persons with disabilities in institutions.

Petitioners rely (Br. 26) on several lower-court decisions to support their view that there was a judicial consensus rejecting any right to community placement under Section 504. But of the decisions cited by petitioners, three were decided after Congress enacted the ADA, *P.C. v. McLaughlin*, 913 F.2d 1033 (2d Cir. 1990); *Jackson v. Fort Stanton Hosp. & Training Sch.*, 757 F. Supp. 1243 (D.N.M. 1990), rev'd on other grounds, 964 F.2d 980 (10th Cir. 1992); *People First v. Arlington Dev. Ctr.*, 878 F. Supp. 97 (W.D. Tenn. 1992)), and one of the cases did not decide the issue, *S.H. v. Edwards*, No. C81-877A (N.D. Ga. Apr. 10, 1987), aff'd, 860 F.2d 1045 (11th Cir. 1988), cert. denied, 491 U.S. 905 (1989). More important, petitioners ignore the decisions that held or assumed that Section 504 requires community placement in certain circumstances. *Kentucky Ass'n for Retarded Citizens, Inc. v. Conn.*, 674 F.2d 582, 585 (6th Cir.), cert. denied, 459 U.S. 1041 (1982); *Homeward Bound, Inc. v. Hissom Mem'l Ctr.*, No. 85-C-437-E, 1987 WL 27104, at \*20-21 (N.D. Okla. July 24, 1987); *Garrity v. Gallen*, 522 F. Supp. 171, 213-215 (D.N.H. 1981); *Lynch v. Maher*, 507 F. Supp. 1268, 1278-1280 (D. Conn. 1981); *Halderman v. Pennhurst State Sch. & Hosp.*, 446 F. Supp. 1295 (E.D. Pa. 1978), aff'd in part and rev'd in part, 612 F.2d 84 (3d Cir. 1979), rev'd, 451 U.S. 1 (1981). Thus, before enactment of the ADA, the question whether Section 504 prohibited unjustified segregation of persons in institutions was an open one.

*Traynor v. Turnage*, 485 U.S. 535 (1988), relied upon by petitioners (Br. 23), does not hold otherwise. That case held that Section 504 did not repeal a statute that prevented persons with a disability resulting from their own willful misconduct (in this case alcoholism) from using educational benefits provided by the GI bill after the statutory deadline. The Court found "nothing in the Rehabilitation Act that

requires that any benefit extended to one category of handicapped persons, also must be extended to other categories of handicapped persons." 485 U.S. at 549. *Traynor* does not remotely suggest that Section 504 permits the unjustified segregation of persons in institutions.

Petitioners are also incorrect in their assertion (Br. 28) that, prior to enactment of the ADA, no federal administrative agency had interpreted Section 504 to prohibit segregation of persons in institutions. The Department of Justice argued in the *Pennhurst* litigation that, in certain circumstances, Section 504 prohibits unnecessary institutionalization of persons with disabilities. See U.S. Br. at 36-45, *Halderman v. Pennhurst State Sch. & Hosp.*, No. 78-1490 (filed Oct. 2, 1978). Following *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), the Department again argued that Section 504 prohibits unnecessary institutionalization, but indicated that, in light of *Davis*, a State could not be required to create a new system of community facilities where none existed before. See U.S. Br. at 29, *Halderman v. Pennhurst State Sch. & Hosp.*, No. 78-1490 (filed Oct. 14, 1981). The Department did not address the question after *Alexander*, 469 U.S. at 300-301, and *Arline*, 489 U.S. at 287 n.17, clarified the meaning of *Davis*. Because there was no settled judicial or administrative construction of Section 504 on the question presented in this case prior to enactment of the ADA in 1990, the fact that Congress generally patterned Title II of the ADA on Section 504 has no significance here.

2. Petitioners contend (Br. 30-32) that the Attorney General's interpretation of Title II conflicts with the Medicaid Act, because that Act establishes a preference for care in institutions rather than the community. As we have noted, however, the Medicaid Act provides a mechanism by which States may obtain waivers to treat persons in the community. Moreover, HHS has a policy of encouraging States to take advantage of the waiver program, and often



approves more waiver slots than a State ultimately uses. For example, as we have noted, HHS approved up to 2109 waiver slots for Georgia, but Georgia used only 700. In any event, nothing in the Medicaid Act prevents the State from fulfilling its obligations under Title II. To the extent that the State is unable to utilize funding obtained under the Medicaid Act to serve all those who are eligible for treatment in the community, it may use its own resources for that purpose.

Petitioners also contend (Br. 30-32) that the Attorney General's interpretation of Title II conflicts with the Medicaid Act because the Medicaid Act does not provide funding for the community placement of persons who prefer institutional care. Neither Title II nor the Attorney General's regulations, however, require a State to treat an individual in the community if that individual prefers treatment in an institution. See 42 U.S.C. 12201(d); 28 C.F.R. 35.130(e)(1).

Petitioners also err (Br. 32) in attributing "great weight" to Congress's failure to pass legislation that would have made the treatment of persons in the community a requirement for receiving Medicaid funds. That legislation would have gone significantly beyond the requirements in Title II and the integration regulation. More fundamentally, failed legislative proposals do not provide a sound basis for determining the meaning of another statute. *Central Bank v. First Interstate Bank*, 511 U.S. 164, 187 (1994).

3. Petitioners contend (Br. 32-33) that the Attorney General's interpretation of the integration regulation is inconsistent with the "clear statement" rule set forth in *Gregory v. Ashcroft*, 501 U.S. 452 (1991). In that case, the Court refused to construe ambiguous language in the Age Discrimination in Employment Act of 1967, 29 U.S.C. 621 *et seq.*, to require States to alter their practices concerning when state judges must retire. The Court relied on a canon of statutory construction that, absent an "unmistakably

clear" expression of intent to "alter the usual constitutional balance between the States and the Federal Government," a court should interpret a statute to preserve rather than destroy the States' "substantial sovereign powers." 501 U.S. at 460-461. *Gregory* is inapplicable here for three reasons.

First, contrary to petitioners' understanding (Br. 33), the *Gregory* clear statement rule does not apply simply because a proposed interpretation of a federal statute would affect "an area traditionally regulated by the States." *City of Edmonds v. Oxford House, Inc.*, 514 U.S. 725, 732 n.5 (1995) (refusing to apply a clear statement rule to decide whether the Fair Housing Act, 42 U.S.C. 3601 *et seq.*, applies to zoning restrictions that limit the number of unrelated persons that can occupy a home in a residential community). The clear statement rule applies only when the proposed interpretation would implicate "a decision of the most fundamental sort for a sovereign entity." *Ibid.* The present case does not implicate the type of core sovereignty concerns that were at issue in *Gregory*. Instead, it is much more akin to the kind of imposition on traditional state functions at issue in *City of Edmonds*.

Second, *Gregory's* clear statement rule is merely "a rule of statutory construction to be applied where statutory intent is ambiguous." 501 U.S. at 470; *Salinas v. United States*, 522 U.S. 52, 59-61 (1997). As explained above, Congress's findings concerning "segregation" and "institutionalization" reflect Congress's clear understanding that the unjustified segregation of persons in institutions constitutes a form of discrimination based on disability. And Congress's instruction to the Attorney General in 42 U.S.C. 12134, in essence, required the Attorney General to adopt an integration regulation covering *all* services provided by public entities, including the type of treatment services offered by petitioners in this case. Because there is no ambiguity with

respect to Congress's intent on the question presented in this case, the *Gregory* clear statement rule does not apply.

Finally, even assuming that Congress's intent is ambiguous, Congress directed the Attorney General to issue regulations that would resolve any ambiguities on the scope of Title II's nondiscrimination prohibition. 42 U.S.C. 12134. Since the clear statement rule is nothing more than an aid to resolving Congress's intent on an issue, that rule is inapplicable when Congress expressly delegates authority to an administrative agency to give content to a general statutory prohibition. Cf. *Fidelity Fed. Sav. & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 154 (1982) (agency acting within the scope of its delegated authority may preempt state law, even though a court acting on its own would not conclude that Congress preempted state law unless Congress clearly manifested such an intent).

4. Petitioners' reliance (Br. 33-35) on *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), is also misplaced. The statutory provision at issue there stated that treatment "should be provided in the setting that is least restrictive of the person's personal liberty." 42 U.S.C. 6010(2) (1976) (emphasis added). In the absence of any clear indication that Congress intended through that language to impose a mandatory obligation on the States, the Court held that the provision was merely precatory. 451 U.S. at 19. By contrast, Title II of the ADA, 42 U.S.C. 12132, provides that "no qualified individual with a disability shall, by reason of such disability \* \* \* be subjected to discrimination by any [public] entity" (emphasis added). And the integration regulation provides that "[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. 35.130(d) (emphasis added). "The contrast between the congressional preference at issue in *Pennhurst* and the antidiscrimination mandate of [Title II

and the integration regulation] could not be more stark." *Arline*, 480 U.S. at 286 n.15. *Pennhurst* is therefore inapplicable here. See *Arline*, 480 U.S. at 286 n.15 (holding that *Pennhurst* is not applicable to statutes, like Section 504, that clearly mandate action).

5. Finally, petitioners assert (Br. 44) that the Attorney General's interpretation should be rejected in order to avoid the constitutional question whether Title II as so construed would exceed congressional authority under Section 5 of the Fourteenth Amendment. The principle that a statute should be construed to avoid constitutional doubt is only implicated, however, when the statute is genuinely ambiguous. *Salinas*, 522 U.S. at 59-61. For the reasons we have given, there is no such ambiguity here.

In any event, the prohibition against unjustified segregation of persons in institutions readily satisfies constitutional standards. Legislation will be upheld as a valid exercise of Congress's power under Section 5 of the Fourteenth Amendment if there is a "congruence and proportionality between the injury to be prevented or remedied and the means adopted to that end." *City of Boerne v. Flores*, 521 U.S. 507, 520 (1997). The integration mandate of Title II readily satisfies that test.

Irrational and invidious discrimination on the basis of disability violates the Equal Protection Clause. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432 (1985). Moreover, this Court in *Cleburne* recognized that "irrational prejudice," 473 U.S. at 450, "irrational fears," *id.* at 455 (Stevens, J., concurring), and "impermissible assumptions or outmoded and perhaps invidious stereotypes," *id.* at 465 (Marshall, J., concurring in part and dissenting in part), existed against persons with disabilities and, at times, infected governmental decisionmaking. Congress similarly found that discrimination against persons with disabilities persists in many contexts and that such discrimination is



often the product of impermissible stereotypes and misconceptions. 42 U.S.C. 12101(a)(2), (3), (5) and (7).

The integration regulation is a measured response to the discrimination identified by Congress. It is designed to increase the interaction between persons with disabilities and their non-disabled counterparts, thus hastening the breakdown of the stereotypes that have impeded full equality. The regulation also serves as a prophylactic safeguard against intentionally discriminatory efforts to exclude persons with disabilities from residential communities. Cf. *Katzenbach v. Morgan*, 384 U.S. 641, 654 (1966). At the same time, the regulation is carefully crafted to avoid undue burdens on the States. The Title II integration mandate is therefore well within Congress's power under Section 5 of the Fourteenth Amendment.

#### CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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#### APPENDIX

1. Section 12101 of Title 42 of the United States Code provides in pertinent part:

#### § 12101. Findings and purpose

##### (a) Findings

\* \* \* \* \*

(2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

(3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;

\* \* \* \* \*

(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification

(1a)

standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;

\* \* \* \* \*

(8) the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals; and

\* \* \* \* \*

2. Section 12111 of Title 42 U.S.C. provides in relevant part as follows:

**§ 12111. Definitions**

As used in this subchapter:

\* \* \* \* \*

**(10) Undue hardship**

**(A) In general**

The term "undue hardship" means an action requiring significant difficulty or expense, when considered in light of the factors set forth in subparagraph (B).

**(B) Factors to be considered**

In determining whether an accommodation would impose an undue hardship on a

covered entity, factors to be considered include—

(i) the nature and cost of the accommodation needed under this chapter;

(ii) the overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility;

(iii) the overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities; and

(iv) the type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity.

3. Section 12131 of Title 42 of the United States Code provides as follows:

**§ 12131. Definitions**

As used in this subchapter:

**(1) Public entity**

The term "public entity" means—



- (A) any State or local government;
- (B) any department, agency, special purpose district, or other instrumentality of a State or States or local government; and
- (C) the National Railroad Passenger Corporation, and any commuter authority (as defined in section 24102(4) of title 49).

**(2) Qualified individual with a disability**

The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

4. Section 12132 of Title 42 of the United States Code provides as follows:

**§ 12132. Discrimination**

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

5. Section 12133 of Title 42 of the United States Code provides as follows:

**§ 12133. Enforcement**

The remedies, procedures, and rights set forth in section 794a of title 29 shall be the remedies, procedures, and rights this subchapter provides to any person alleging discrimination on the basis of disability in violation of section 12132 of this title.

6. Section 12134 of Title 42 of the United States Code provides as follows:

**§ 12134. Regulations**

**(a) In general**

Not later than 1 year after July 26, 1990, the Attorney General shall promulgate regulations in an accessible format that implement this part. Such regulations shall not include any matter within the scope of the authority of the Secretary of Transportation under section 12143, 12149, or 12164 of this title.

**(b) Relationship to other regulations**

Except for "program accessibility, existing facilities", and "communications", regulations under subsection (a) of this section shall be consistent with this chapter and with the coordination regulations under part 41 of title 28, Code of Federal Regulations (as promulgated by the Department of Health, Education, and Welfare on January 13,

1978), applicable to recipients of Federal financial assistance under section 794 of title 29. With respect to "program accessibility, existing facilities", and "communications", such regulations shall be consistent with regulations and analysis as in part 39 of title 28 of the Code of Federal Regulations, applicable to federally conducted activities under section 794 of title 29.

7. Section 12182 of Title 42 of the United States Code provides in pertinent part:

**§ 12182. Prohibition of discrimination by public accommodations**

\* \* \* \* \*

**(b) Construction**

**(1) General prohibition**

\* \* \* \* \*

**(B) Integrated settings**

Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.

8. Section 35.130 of Title 28 of the Code of Federal Regulations provides as follows:

**§ 35.130 General prohibitions against discrimination.**

(a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

(b)(1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability—

(i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

(iv) Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary



to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

(v) Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

(vi) Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;

(vii) Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

(2) A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(3) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

(i) That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;

(ii) That have the purpose or effect of defeating or substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or

(iii) That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.

(4) A public entity may not, in determining the site or location of a facility, make selections—

(i) That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or

(ii) That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.

(5) A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.

(6) A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities

that subject qualified individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.

(7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

(8) A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.

(c) Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.

(d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

(e)(1) Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

(2) Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

(f) A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

(g) A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.



6

Supreme Court, U.S.

FILED

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No. 98-536

**IN THE SUPREME COURT OF THE UNITED STATES  
OCTOBER TERM, 1998**

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**TOMMY OLMSTEAD**, Commissioner of the Department  
of Human Resources of the State of Georgia, et al.,

Petitioners,

vs.

**L. C. and E. W.**, each by **JONATHAN ZIMRING**,  
as guardian ad litem and next friend,

Respondents.

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**On Writ Of Certiorari  
To The United States Court of Appeals  
For The Eleventh Circuit**

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**AMICUS CURIAE BRIEF OF THE STATES\*  
IN SUPPORT OF PETITIONERS**

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## TABLE OF CONTENTS

|  |    |
|--|----|
| List of Parties Joining in Brief ..... | ii |
| Table of Contents .....                | iv |
| Table of Authorities .....             | vi |
| Interest of Amici .....                | 1  |
| Summary of Argument .....              | 2  |
| Argument .....                         | 3  |

**I. THE ADA AS INTERPRETED BY THE  
 INTEGRATION RULE UNDERMINES THE  
 STATES' ABILITY TO DECIDE THE MOST  
 APPROPRIATE STRUCTURE FOR  
 DELIVERING SERVICES AND PROGRAMS  
 FOR TREATMENT AND HABILITATION OF  
 INDIVIDUALS WITH DISABILITIES AND  
 FOR ALLOCATION OF THE STATES'  
 LIMITED RESOURCES..... 3**

**II. THE COURT OF APPEALS  
 MISINTERPRETED CONGRESS' INTENT  
 AS STATED IN THE ADA. .... 9**

**A. Title II of the ADA Bars Only  
 Discrimination Based on Disability ..... 11**

**B. The Integration Rule Implementing  
 The Rehabilitation Act Did Not Require  
 The States To Place Handicapped Individuals  
 In The Most Integrated Setting Appropriate  
 To Their Needs ..... 14**

**III. THE ADA CANNOT BE CONSTRUED  
TO IMPOSE FINANCIAL BURDENS UPON  
THE STATES IN THE ABSENCE OF  
CONGRESS' CLEARLY STATED INTENT . . . 16**

Conclusion . . . . . 18

**TABLE OF AUTHORITIES**

**FEDERAL CASES**

|   |        |
|---|--------|
| <u>Alexander v. Choate</u> , 469 U.S. 287 (1985) . . . . .  | 12     |
| <u>Andrews v. Ohio</u> , 104 F.3d 803 (6th Cir. 1997) . . . . .   | 12     |
| <u>Bragdon v. Abbott</u> , 118 S. Ct. 2196 (1998) . . . . .   | 14     |
| <u>Helen L. v. Didario</u> , 46 F.3d 325 (3rd Cir. 1995)<br>cert. den. sub nom. <u>Pennsylvania Secretary of<br/>Public Welfare v. Idell S.</u> , 511 U.S. 813 (1995) . . . . . | 7      |
| <u>Kornblau v. Dade County</u> , 86 F.3d 193 (11th Cir. 1996) . .   | 12     |
| <u>L.C. v. Olmstead</u> , 138 F.3d 893 (11th Cir. 1998) . . . . .   | 7, 8   |
| <u>Lelsz v. Kavanagh</u> , 807 F.2d 1243 (5th Cir. 1987) . . . . .  | 13     |
| <u>McPherson v. Michigan High Sch.<br/>Athletic Association, Inc.</u> , 119 F.3d 453 (6th Cir. 1997) . .  | 12     |
| <u>Miller v. Johnson</u> , 515 U.S. 900 (1995) . . . . .  | 11, 13 |
| <u>New York v. United States</u> , 505 U.S. 144 (1992) . . . . .  | 18     |
| <u>P.C. v. McLaughlin</u> , 913 F.2d 1033 (2d Cir. 1990) . .  | 13, 14 |
| <u>Parker v. Metropolitan Life Insurance Co.</u> ,<br>121 F.3d 1006 (6th Cir. 1997),<br>cert. denied, ___ U.S. ___, 118 S. Ct. 871 (1998) . . . . .                             | 12     |
| <u>Pennhurst State School &amp; Hospital v. Halderman</u> ,<br>451 U.S. 1 (1981) . . . . .  | 16, 17 |
| <u>Phillips v. Thompson</u> , 715 F.2d 365 (7th Cir. 1983) . . . .  | 15     |



|   |        |
|---|--------|
| <u>Printz v. United States</u> , 117 S. Ct. 2365 (1996) . . . . .   | 18     |
| <u>Reno v. Bossier Parish Sch. Board</u> , 520 U.S. 471,<br>117 S. Ct. 1491 (1997) . . . . .                  | 11, 13 |
| <u>Seminole Tribe of Florida v. Florida</u> ,<br>517 U.S. 44 (1996) . . . . .                                 | 13, 18 |
| <u>Society for Good Will to Retarded Children, Inc.<br/>v. Cuomo</u> , 737 F.2d 1239 (2d Cir. 1984) . . . . . | 13     |
| <u>Traynor v. Turnage</u> , 485 U.S. 535, 108 S. Ct. 1372,<br>99 L. Ed. 2d 618 (1988) . . . . .               | 12     |
| <u>United States v. Board of Commissioners of Sheffield</u> ,<br>435 U.S. 110 (1978) . . . . .                | 15     |
| <u>Wernick v. Federal Reserve Bank of New York</u> ,<br>91 F.3d 379 (2d Cir.1996) . . . . .                   | 12     |
| <u>Williams v. Wasserman</u> ,<br>937 F. Supp. 524 (D.Md. 1996) . . . . .                                     | 6      |

#### DOCKETED CASES

|   |         |
|---|---------|
| <u>Best v. DeBuono</u> , Case No. 98-404648 . . . . .           | 5       |
| <u>Brown v. Chiles</u> , Case No. 98-673-CIV-Ferguson . . . .   | 4, 8, 9 |
| <u>Charles M. v. Gilbert</u> , Case No. SA-98-CA-0676-DWS . . . | 5       |
| <u>Damian M. v. Gilbert</u> , Case No. CA-H-98-3702 . . . . .   | 5       |
| <u>Jackson v. DeBuono</u> , Case No. 98-402855 . . . . .        | 5       |
| <u>Johnson v. Sellars</u> , Case No. 87-369-CIV-T-24 . . . . .  | 5, 8    |

|   |   |
|---|---|
| <u>Rivera v. DeBuono</u> , Case No. 98-402685 . . . . .   | 5 |
| <u>Rodriguez v. DeBuono</u> ,<br>Case Number 97-CIV-0700(SAS) . . . . .   | 6 |
| <u>Rubin v. DeBuono</u> , Case No. 98-402767 . . . . .  | 5 |
| <u>Sanon v. DeBuono</u> , Case No. 98-403296 . . . . .  | 5 |
| <u>Travis D. v. Eastmont Human Services Center</u> ,<br>U. S. District Court, District of Montana,<br>Case No. CV-96-63-H-CCL . . . . . | 6 |

## FEDERAL STATUTES AND REGULATIONS

|   |                  |
|---|------------------|
| 28 C.F.R. §35.130(d) . . . . .                | <i>en passim</i> |
| 29 U.S.C. §794 . . . . .                      | <i>en passim</i> |
| 42 U.S.C. § 6000 et seq . . . . .             | 16               |
| 42 U.S.C. §12131, et seq. (the ADA) . . . . . | 1                |
| 42 U.S.C. §12132 . . . . .                    | <i>en passim</i> |
| 42 U.S.C. §12134(b) . . . . .                 | 10, 14           |
| 42 U.S.C. 12182 (b)(1) (B) . . . . .          | 15               |

## CONSTITUTION

|                                     |    |
|-------------------------------------|----|
| XIV Amend., U.S. Const. . . . .     | 14 |
| XV Amend., § 2, U.S. Const. . . . . | 14 |

## MISCELLANEOUS

|   |   |
|---|---|
| David Braddock et al., <u>The State of the States<br/>in Developmental Disabilities: Summary<br/>of the Study</u> (5th ed.) . . . . . | 9 |
|---|---|

## INTEREST OF AMICI CURIAE

The issue presented in this case is whether Title II of the Americans with Disabilities Act, 42 U.S.C. §12131, et seq. (the "ADA"), and the Integration Rule<sup>1</sup> compel the delivery of disability services (*i.e.*, services that are provided only for habilitation and treatment of the disabled, and not to nondisabled persons) in the most integrated community setting available, when such treatment and habilitation can also be provided in an institutional setting. The states have an obvious and compelling interest in this question. All of the states provide services and programs for the treatment and habilitation of individuals with disabilities. This diverse group includes, *inter alia*, those who may be mildly, moderately, severely or profoundly mentally retarded; those who have other mental or physical disorders; and those requiring treatment for substance abuse.

The states provide treatment and services to individuals with disabilities in both institutional and community-based settings. In addition to hospital-type institutions, states also provide "intermediate" settings at the community level such as nursing homes, assisted living facilities, and Intermediate Care Facilities for the Mentally Retarded (ICF/MR). Representative information for thirteen states is set forth in Appendix A.

The needs of individuals with disabilities vary widely. Some of those who are treatable in a community setting may, nevertheless, require a restrictive and structured placement to accommodate their special needs. Others, who have more medically complex disabilities, will require specialized medical services, specialized medical equipment, and 24-hour nursing services, considerations that make community placement more problematic. Still others may pose serious risks to the community

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<sup>1</sup>This rule is also referred to as the "Integration Mandate." See 28 C.F.R. §35.130(d)



because of extreme behavioral problems or even criminal propensities. There are social and political, as well as fiscal, costs involved in community placement for these individuals.

Many of the states are now embroiled in costly and protracted lawsuits that, relying on the Integration Rule's interpretation of the ADA, seek to fundamentally reshape the manner in which services (that are not provided to nondisabled persons) are provided to individuals with disabilities. The overall thrust of this litigation is toward massive deinstitutionalization, regardless of the disruption and regardless of the short-term costs. In many states, a modification in the service delivery system to require the provision of treatment and programs for every disabled individual in the least restrictive setting appropriate to the needs of the individual would require the expenditure of hundreds of millions of dollars, perhaps more. The states' interest in having the question of Congress' intent regarding the Integration Mandate resolved is clearly compelling.

### SUMMARY OF ARGUMENT

The states' delivery of treatment, services and programs for individuals with disabilities is a complex and expensive undertaking and one that should be carefully planned. States now face numerous lawsuits, including class actions, asserting that every individual with a disability has a right to be treated in the least restrictive setting, regardless of the cost and regardless of the impact on any state's current structure of institutional, group and community-based facilities. The states' ability to provide services to those with disabilities is undermined by constant litigation to determine every individual's proper placement.

In enacting the ADA, Congress authorized the Department of Justice to adopt implementing regulations consistent with those it had adopted under the Rehabilitation Act. The ADA, however, contains no mandate for deinstitutionalization. Rather, it prohibits

discrimination against an individual on the basis of that person's disability. That is, discrimination between an individual with a disability and the non-disabled. Courts have not recognized that an individual with a disability has a constitutional right to habilitation in the least restrictive environment.

Furthermore, the Rehabilitation Act was not interpreted to require the states to place individuals with disabilities in the least restrictive setting appropriate to the needs of the individual. Hence, it could not have been Congress' intent to mandate the adoption of a new rule by the Department of Justice (or a substantially different new interpretation of an existing rule) requiring the provision of treatment, services and habilitation for every individual with a disability in the most integrated setting.

Finally, principles of federalism require that Congress provide "clear notice" to states in the text of legislation when it imposes obligations upon the states -- such as deinstitutionalization -- that will entail significant costs. The ADA does not meet the requisite clear notice requirement.

### ARGUMENT

#### I. THE ADA AS INTERPRETED BY THE INTEGRATION RULE UNDERMINES THE STATES' ABILITY TO DECIDE THE MOST APPROPRIATE STRUCTURE FOR DELIVERING SERVICES AND PROGRAMS FOR TREATMENT AND HABILITATION OF INDIVIDUALS WITH DISABILITIES AND FOR ALLOCATION OF THE STATES' LIMITED RESOURCES.

The management and delivery of services and programs for the treatment and habilitation of individuals with disabilities is a major, complex and expensive undertaking for every state, but particularly so for those more populous states whose annual

budgets for such services may reach hundreds of millions of dollars. Many states have long relied on institutions as a significant component of their systems for delivering treatment and habilitation services for individuals with disabilities. States such as Michigan and Montana, over time and of their own volition, have moved to predominantly community settings for providing treatment and habilitation services. But none has ever understood that the ADA mandated an immediate transition (or even a transition over time) to a community setting for each and every individual for whom it was a theoretical possibility.

It is, of course, self-evident that if a state expends enough money and provides sufficient equipment and personnel, virtually any person can be served either in an integrated community setting or in his or her own home. Limited fiscal resources restrict the ability of the states to fund community-based placements for all individuals with disabilities. Nevertheless, relying on the Integration Rule, a host of ADA-based claims have been filed throughout the country that attack not only the provision of services in institutions, but also those in less integrated settings like an Intermediate Care Facility for the Mentally Retarded and even nursing homes. Consider the following cases:

#### A. Florida

*Brown v. Chiles*, Case No. 98-673-CIV-Ferguson, U.S. District Court, Southern District of Florida, a class action challenging the placement of developmentally disabled persons in the four Developmental Services Institutions (DSIs) owned and operated by the State of Florida. These DSI institutions provide residential treatment and habilitation for approximately 1,400 severely or profoundly retarded and developmentally disabled adults. In demanding the "most integrated placement" for each of these 1,400 individuals along with all necessary support services, plaintiffs effectively seek the closure of the facilities.

*Johnson v. Sellars*, Case No. 87-369-CIV-T-24, U.S. District Court, Middle District of Florida, a case in which, following the state's settlement with the plaintiff class' challenge to conditions at the G. Pierce Wood Memorial Hospital, a facility for those with mental disorders, the court permitted the Department of Justice to intervene in 1998. The Department asserts, *inter alia*, that the patients at the hospital are not receiving services in the most integrated setting appropriate to their needs. This suit also effectively seeks closure of the facility.

#### B. Texas

*Damian M. v. Gilbert*, Case No. CA-H-98-3702, U. S. District Court, South District, Houston Division, a case in which the plaintiff, a resident of a private ICF/MR, seeks services at home. The program has a waiting list and plaintiff is ranked 460 on that list. Plaintiff asserts the ADA mandates the most integrated setting possible--in his case, at home.

*Charles M. v. Gilbert*, Case No. SA-98-CA-0676-DWS, U. S. District Court, a case challenging the denial of home and community-based services. The denial was predicated on a determination that such services would exceed the cost of nursing home care.

#### C. New York

*Best v. DeBuono*, Case No. 98-404648, Supreme Court, New York County; *Jackson v. DeBuono*, Case No. 98-402855, Supreme Court, New York County; *Rivera v. DeBuono*, Case No. 98-402685, Supreme Court, New York County; *Rubin v. DeBuono*, Case No. 98-402767, Supreme Court, New York County; *Sanon v. DeBuono*, Case No. 98-403296.

These cases concern Medicaid recipients applying for or receiving personal care services. If the home care costs exceed 90 percent of nursing facility costs, the recipient, if not meeting any



exception, must be referred for nursing facility placement or other appropriate placement. Plaintiffs assert this policy violates the ADA.

Additionally, another case is pending in New York involving "safety monitoring" services, *Rodriguez v. DeBuono*, Case Number 97-CIV-0700(SAS), currently pending in the Southern District of New York. In these cases, it is contended that New York must provide "safety monitoring" as part of the home-based personal care services program for those recipients who are cognitively impaired. New York contends that the personal care services program is only to provide hands-on assistance with specific tasks and that it would alter the essential nature of the program if the state had to provide safety monitoring when no other personal care service is being provided.

#### D. Maryland

*Williams v. Wasserman*, 937 F.Supp. 524, 526 (D.Md. 1996). Nine plaintiffs, described as "traumatically brain injured" and developmentally disabled, brought claims on behalf of a class alleging that the failure of the state to provide community-based rather than institutional care violated the integration mandate. On summary judgment motions, the court concluded that requiring the state to provide community placements was a "reasonable accommodation" to their disability. Factual issues remained which precluded summary judgment.

#### E. Montana

*Travis D. v. Eastmont Human Services Center*, U. S. District Court, District of Montana, Case No. CV-96-63-H-CCL. In this case, the plaintiffs seek to require Montana to evaluate each person with developmental disabilities being served or at risk of commitment to Montana's two state-operated ICF/MRs and to provide services in community settings to any who could be

appropriately served in such settings, even if this means creating new or expanding existing community services.

Montana presently has about 120-125 individuals who are served in ICF/MRs. This population requires a high level of well-coordinated services that are much more expensive to provide than those available in the community to individuals whose needs are not so complex. Plaintiffs have presented a "functional twin" argument--that there are other individuals requiring approximately the same configurations of services who are being cared for in the community. Therefore, it is contended, Montana is capable of providing such services, and it would not cause a fundamental or substantial alteration to the service system to require Montana to develop additional similar placements.

\* \* \*

The impetus for the above suits was *Helen L. v. Didario*, 46 F.3d 325 (3rd Cir. 1995), *cert. den. sub nom. Pennsylvania Secretary of Public Welfare v. Idell S.*, 511 U.S. 813 (1995), as extended by the court of appeals' decision in the instant case, *L.C. v. Olmstead*, 138 F.3d 893 (11th Cir. 1998). Both purport to deny that their rulings mandate the deinstitutionalization of individuals with disabilities. See *Helen L.*, 46 F.3d at 336, and *Olmstead*, 138 F.3d at 902. In *Helen L.*, the plaintiff, who was partially paralyzed and in a nursing home, sought the provision of state services at home. As a defense, the state contended not that home-based provision of services was more expensive or even that it lacked funds, but simply that it could not shift funds from a nursing care appropriation to the attendant care category. The court held that the plaintiff's request was not unreasonable and noted that it would save the state an average of \$34,500 per year. *Olmstead* significantly extended that ruling, rejecting Georgia's contention that it lacked funding and holding that a state could justify its failure to provide treatment to individuals in the most integrated setting only if the accommodation "would

fundamentally alter the nature of the [state's] service [or] program . . . " See 138 F.3d at 902 and 904.

If this is true for plaintiffs in the singular, as in *Olmstead*, it logically follows that it is true in the aggregate. Indeed, *Brown v. Chiles*, *supra*, and *Johnson v. Sellars*, *supra*, reflect a strategy of seeking deinstitutionalization through class actions challenging institutional placements. Piecemeal litigation rather than planning may now determine the manner in which services will be provided to individuals with disabilities.

The court of appeals in *Olmstead* gave very little guidance as to what would constitute a "fundamental alteration" in the services a state provides. It appears that a state must absorb both the fixed overhead costs necessary to maintain its institutional facilities *and* fund the extra costs of community or home-based treatment until some unknown point at which there is a "fundamental alteration" to its programs. *Olmstead*, 138 F.3d at 905. The difficulty the court of appeals had in its terse discussion of this issue, *see id.*, at 905 and n. 10, pointedly underscores the fact that the "fundamental alteration" standard provides no criterion at all by which a state can, with some degree of intelligent foresight, plan and fund the services it will provide to individuals with disabilities.

The ADA and the Integration Mandate should not be used to deprive the states of the right to make their own considered plans for the structuring of treatment and habilitation services for individuals with disabilities, particularly regarding the appropriate mix of institutional, group and community-based settings. Given its generality of expression, the mandate has no logical or discernible point of attenuation. It necessarily invites never-ending litigation by individuals to determine the "least restrictive" placements and to obtain the services to go with them, even if the state has decided that those services should be provided in institutional or group settings.

If institutions begin to empty, the facility-based reimbursement schemes in place nationwide will be undermined because of the resultant diseconomies of scale. These institutions typically are reimbursed based on a daily bed rate, and to provide the best services must operate at capacity. The per capita daily rate will certainly rise as the cost is spread over a decreasing population.<sup>2</sup> Hence, a reduction in the quality of services provided can be anticipated. Moreover, the compelled creation of new community placements hurriedly planned will engender its own set of problems. Ultimately, states will have to decide whether in the face of limited resources they can serve only the most severely disabled.

It is submitted that nothing in the ADA or its history reflects that Congress intended to usurp the states' prerogative to make these fundamental policy decisions themselves. To the contrary, Congress' mandate, as shown *infra*, was much more limited.

## II. THE COURT OF APPEALS MISINTERPRETED CONGRESS' INTENT AS STATED IN THE ADA.

When it enacted the ADA, Congress stated that the Attorney General was to promulgate regulations implementing the ADA, and that

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<sup>2</sup> See, e.g., David Braddock et al., *The State of the States in Developmental Disabilities: Summary of the Study* (5th ed.) at p. 27, where the authors note that although institutional populations were continuing to decline:

Aggregate staffing of institutions has declined substantially but less rapidly than the residential census. As a result, *average daily costs have risen substantially....*

(emphasis added).



[w]ith respect to "program accessibility, existing facilities," and "communications," such regulations shall be consistent with regulations and analysis as in part 39 of title 28 of the Code of Federal Regulations, applicable to federally conducted activities under such section 794 of Title 29 [the Rehabilitation Act].

42 U.S.C. §12134(b). Thus, Congress required the Department of Justice to adopt regulations consistent with those the Department had promulgated when implementing the Rehabilitation Act. One of the rules implementing the Rehabilitation Act, known as the "integration regulation," provided that "[t]he agency shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons." See 28 C.F.R. § 39.130(d).

In accordance with Congress's mandate in 42 U.S.C. § 12134(b) that it promulgate regulations implementing the ADA that were consistent with its existing regulations implementing the Rehabilitation Act, the Department adopted a nearly identical integration rule:

A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

See 28 C.F.R. § 35.130(d). The court of appeals concluded that because the Department has interpreted this regulation as requiring the states to place institutionalized individuals with disabilities in "the most integrated setting appropriate" to the needs of each individual, the ADA requires such placement, even if facilities for that placement do not presently exist, and even though the states do not provide similar services to individuals without disabilities.

The court of appeals' decision on this point was incorrect. Even if the Department interprets the regulation as requiring the states to place individuals with disabilities in the most integrated setting possible, regardless of whether the states currently provide such services to non-disabled individuals, that interpretation is not binding on the courts if Congress has otherwise expressed its intent on the question. See *Reno v. Bossier Parish Sch. Bd.*, 520 U.S. 471, 117 S.Ct. 1491, 1500 (1997) (citation omitted) (holding that "[a]lthough we normally accord the Attorney General's construction of the Voting Rights Act great deference, 'we only do so if Congress has not expressed its intent with respect to the question, and then only if the administrative interpretation is reasonable'"). Cf. also *Miller v. Johnson*, 515 U.S. 900, 923 (1995) (citations omitted) (stating that "[a]lthough we have deferred to the Department's interpretation in certain statutory cases, . . . we have rejected agency interpretations to which we would otherwise defer where they raise serious constitutional questions"). Thus, if Congress has indicated that it did *not* intend to require the states to provide treatment to disabled persons in the "most integrated setting" appropriate for each individual disabled person, then this Court must reject the Department's construction of the integration regulation.

#### A. Title II of the ADA Bars Only Discrimination Based on Disability.

In enacting Title II of the ADA, Congress stated that:

Subject to the provisions of this subchapter, no qualified individual with a disability shall, *by reason of such disability*, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132 (emphasis added).

Congress thus enacted the ADA in order to prohibit the states from denying to disabled persons, because of their disabilities, the services and benefits provided to and enjoyed by those without disabilities. *See, e.g., Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1015-1016 (6th Cir. 1997) (en banc) (holding that "the ADA does not mandate equality between individuals with different disabilities. Rather, the ADA prohibits discrimination between the disabled and the non-disabled."), *cert. denied*, \_\_\_ U.S. \_\_\_, 118 S.Ct. 871 (1998); *Wernick v. Federal Reserve Bank of New York*, 91 F.3d 379, 384 (2d Cir.1996) (holding that when it enacted the ADA, "Congress intended simply that disabled persons have the same opportunities available to them as are available to nondisabled persons."); *Kornblau v. Dade County*, 86 F.3d 193, 194 (11th Cir. 1996) (citation omitted) (holding that "nothing in the Act [ADA], its purpose, or the regulations can reasonably be read to give disabled parkers access to areas that would not be available to them if they were not disabled. The purpose of the Act is to place those with disabilities on an equal footing, not to give them an unfair advantage."). *Cf. also Alexander v. Choate*, 469 U.S. 287, 304 (1985) (stating that the Rehabilitation Act "seeks to assure evenhanded treatment and the opportunity for handicapped individuals to participate in and benefit from programs receiving federal assistance").<sup>3</sup> However, the ADA does *not* require the states to treat all disabled persons in the same manner. *Cf. Traynor v. Turnage*, 485 U.S. 535, 548, 108 S.Ct. 1372, 1382, 99 L.Ed. 2d 618 (1988) (holding that "[t]here is nothing in the Rehabilitation Act that requires that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons").

<sup>3</sup>*See, e.g., McPherson v. Michigan High Sch. Athletic Ass'n, Inc.*, 119 F.3d 453, 459 (6th Cir. 1997) (acknowledging that "[i]t is well-established that the two statutes [the ADA and the Rehabilitation Act] are quite similar in purpose and scope"); *Andrews v. Ohio*, 104 F.3d 803, 807 (6th Cir. 1997) (holding that "[b]ecause the standards under both [the ADA and the Rehabilitation Act] are largely the same, cases construing one statute are instructive in construing the other").

Where an individual with a disability seeks services not available to those who have no disabilities, it cannot be said that the denial of such services in the most integrated setting is by reason of disability. Nevertheless, the court of appeals construed the ADA and the integration regulation to require the states to provide the "most integrated" treatment appropriate for each disabled individual *even if a state does not provide such services for non-disabled persons*. This construction, requiring a comparison of individuals with disabilities only against other disabled persons to determine whether people suffering from similar disabilities are being treated the same, and prohibiting dissimilar treatment, is contrary to Congress' stated intention of prohibiting the states from discriminating against disabled persons by denying them services provided to non-disabled persons. This Court is therefore not bound by the Department's construction of the regulation.<sup>4</sup> *Reno v. Bossier Parish Sch. Bd.*, *supra*.

<sup>4</sup>To the extent that the court of appeals determined that institutionalization is a form of discrimination, it is also worth noting that all of the courts that have addressed the issue have held that the Constitution does *not* guarantee a mentally retarded person the right to the community placement of his choice or in the least restrictive environment. *See, e.g., P.C. v. McLaughlin*, 913 F.2d 1033, 1042 (2d Cir. 1990); *Lelsz v. Kavanagh*, 807 F.2d 1243, 1251 (5th Cir. 1987) (holding that "the federal constitution does not confer on [class of mentally disabled individuals] a right to habilitation in the least restrictive environment"); *Society for Good Will to Retarded Children, Inc. v. Cuomo*, 737 F.2d 1239, 1248 (2d Cir. 1984) (holding that there is no entitlement to community placement or a "least restrictive environment" for mentally retarded persons under the federal constitution). To the extent a mentally retarded person is now guaranteed the right to live in the least restrictive environment, the states have been required to do more than the Constitution itself requires. Such an interpretation of the ADA brings that Act into tension with the Eleventh Amendment. *See Seminole Tribe of Florida v. Florida*, 517 U.S. 44 (1996) (holding that Congress may abrogate the states' Eleventh Amendment immunity from suit in federal court only through a valid exercise of its section 5 power to enforce the Fourteenth Amendment). Thus, although the question of whether Congress exceeded its section 5 power to enforce the Fourteenth Amendment when it enacted Title II of the ADA is not before the Court, the ruling below "raise[s] serious constitutional questions." *See Miller v. Johnson, supra*, 515 U.S. at 926, 115 S.Ct. at 2493 (rejecting Justice Department's interpretation of a portion of the Voting Rights Act where the



**B. The Integration Rule Implementing The Rehabilitation Act Did Not Require The States To Place Handicapped Individuals In The Most Integrated Setting Appropriate To Their Needs.**

When it enacted the ADA, Congress expressly required the Department to promulgate regulations that *were consistent with its existing regulations implementing the Rehabilitation Act*. See 42 U.S.C. § 12134(b). The Department was authorized to do no more than readopt the preexisting regulation that it had promulgated under the Rehabilitation Act. In reality, then, it was the integration regulation of the Rehabilitation Act that Congress gave the "force of law" when it enacted the ADA. The meaning of that regulation is controlling here. See *Bragdon v. Abbott*, 118 S.Ct. 2196, 2208 (1998) ("Had Congress done nothing more than copy the Rehabilitation Act definition into the ADA, its action would indicate the new statute should be construed in light of this unwavering line of administrative and judicial interpretation"). Accordingly, the crucial question is whether the integration regulation set forth in 28 C.F.R. § 39.130(d) (under the Rehabilitation Act) was interpreted, *prior to Congress's enactment of the ADA*, to require the states to provide treatment to individuals with disabilities in the most integrated setting appropriate to the individual, regardless of whether such a setting existed.

Prior to Congress' enactment of the ADA, the courts had consistently held that the Rehabilitation Act did *not* require the states to place handicapped persons in the least restrictive setting appropriate to the individual. See, e.g., *P.C. v. McLaughlin*, 913 F.2d 1033, 1041 (2nd Cir. 1990) (holding that the Rehabilitation

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Department's "implicit command that States engage in presumptive unconstitutional race-based districting brings the Voting Rights Act, once upheld as a proper exercise of Congress' authority under § 2 of the Fifteenth Amendment . . . into tension with the Fourteenth Amendment").

Act "does not require all handicapped persons to be provided with identical benefits," and that the Act "did not clearly establish an obligation to meet P.C.'s particular needs vis-a-vis the needs of other handicapped individuals, *but mandated only that services provided nonhandicapped individuals not be denied P.C. because he is handicapped*" (emphasis added); *Phillips v. Thompson*, 715 F.2d 365, 368 (7th Cir. 1983) (rejecting appellants' argument that the state had the affirmative duty under the Rehabilitation Act "to create less restrictive community residential settings for them," and holding that because "there is no contention that these class members, *because of their handicap*, are being denied access to community residential living that Illinois is affording to others," the Rehabilitation Act "simply has no application to appellants' claim") (emphasis added). The Rehabilitation Act therefore was never interpreted to require placement of handicapped individuals in the most integrated setting appropriate for the individual, despite the existence of the integration regulation within the regulations implementing the Act. Thus, because it was this interpretation of the Rehabilitation Act and its integration regulation which Congress approved and gave the force of law when it enacted the ADA, the court of appeals clearly erred when it overlooked the prior regulation, and instead concluded that it was "bound" by the Department's current construction of the ADA's integration regulation. See *United States v. Board of Comm'rs of Sheffield*, 435 U.S. 110, 134 (1978) (citations omitted) (holding that "[w]hen a Congress that re-enacts a statute voices its approval of an administrative or other interpretation thereof, Congress is treated as having adopted that interpretation, and this Court is bound thereby").

In addition, Congress knows very well how to enact an explicit integration mandate that imposes new and affirmative obligations, and it did so in Title III of the ADA. See 42 U.S.C. § 12182 (b)(1) (B). Had it intended to go beyond the requirement of the previously adopted rule and the courts' construction of the Rehabilitation Act, it could easily have declared its intent to do so.

In sum, the court of appeals' determination that the ADA requires the states to place individuals with disabilities in the most integrated setting appropriate for their needs runs directly contrary to Congress' stated intent. Again, the court of appeals held that the integration regulation requires the states to provide the most integrated treatment setting appropriate for a particular disabled individual *even if a program providing such a setting is not currently available to anyone, disabled or non-disabled*. Obviously, if a state does not provide such a service to non-disabled persons, then the individual with a disability seeking that service is *not* being denied the service because of his or her disability. The state's denial of that service therefore does not violate the ADA. Furthermore, to the extent that it requires the states to provide the "most integrated treatment" to *all* individuals with disabilities because it is able to provide such treatment to *some* of them, the ruling below is contrary to Congress's intent because the ADA simply does not require the states to treat all individuals with disabilities in the same manner. This Court therefore should reverse the determination that the ADA requires the states to create facilities and programs which provide the "most integrated treatment" appropriate for every individual with a disability.

### III. THE ADA CANNOT BE CONSTRUED TO IMPOSE FINANCIAL BURDENS UPON THE STATES IN THE ABSENCE OF CONGRESS' CLEARLY STATED INTENT.

In *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), this Court refused to construe the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000 et seq., as creating a substantive right in favor of the mentally retarded to appropriate treatment in the least restrictive environment. This Court found no clearly stated intent on the part of Congress to impose such an obligation on the states pursuant to its authority to enforce the Fourteenth Amendment or its authority under the Spending Clause to condition the states' receipt of

federal funds under the Act. Rather, in view of the nominal amount of funding available to Pennsylvania under the Act, the Court found that "it defied common sense . . . to suppose that Congress *implicitly* imposed this massive obligation on participating States." *Id.* at 24 (emphasis added). Had it intended to impose such massive burdens, Congress was obligated to provide "clear notice" to the states in the terms of the Act so that any state deciding to participate could make an informed choice whether to do so. *Id.*

The ADA fails to provide clear notice of Congress' intent to mandate that all services provided by the states to individuals with disabilities be provided in the least restrictive or "most integrated" setting for every individual for whom it is theoretically appropriate. Such a mandate would effectively obligate states to conduct an individualized review of each person being treated in an institution to determine whether he or she can be treated in the community; and to create or expand facilities for community-based placements, with the concomitant need to close institutions when provision of services in that setting is no longer economically feasible. At the time the Rehabilitation Act (and the ADA) was passed, there were innumerable institutional facilities, a fact certainly well known to Congress. If Congress intended that all services and programs for individuals with disabilities be provided in the least restrictive setting and institutional facilities phased out, *Pennhurst* requires that intention be clearly stated in the text of the legislation.

If, as a rule of statutory construction, this Court holds that Congress must clearly express its intent to impose conditions on the grant of federal funds to the States, it is all the more imperative to rigorously apply this interpretive rule to legislation that imposes massive obligations *without* funding assistance and that the states



have no choice but to accept.<sup>5</sup> In this circumstance it is not the states' right to make an informed decision that is imperilled, but their far more fundamental right and ability to participate effectively in the political process. Congress should not be permitted to bury invisible landmines in legislation that later explode to the devastation of a state's fisc. Such a practice is intolerable in a system of dual sovereigns. It is every bit as important to concerns of federalism that notice of such an obligation be as clearly stated in legislation as notice of Congress' intent to abrogate the states' sovereign immunity under the Eleventh Amendment. *See Seminole Tribe of Florida v. Florida*, 517 U.S. 44, 54 (1996) (Congress' intent to abrogate the Eleventh Amendment must be "unmistakably clear in the language of the statute"). The ADA plainly does not meet the clear notice standard.

### CONCLUSION

For the foregoing reasons, the decision of the court of appeals should be reversed, and the matter should be remanded to the district court with instructions to dismiss the action below.

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<sup>5</sup> Of course, unless Congress is properly enforcing the Fourteenth Amendment, it cannot impose such obligations upon the states without running afoul of the Tenth Amendment. *See New York v. United States*, 505 U.S. 144 (1992); *Printz v. United States*, 117 S.Ct. 2365 (1996).

Respectfully submitted,

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## INDEX TO APPENDIX

|   | <i>Page(s)</i> |
|---|----------------|
| A. Representative Information for<br>Thirteen States Services to Individuals<br>with Developmental Disabilities ..... | A-1            |



# Appendix A<sup>1</sup>

| State   | Institution  | ICF/MR   | Community Based Care                 |
|---------|--|--|--------------------------------------|
| Florida | 4 developmental services institutions (combined census is approximately 1,415)   | private ICF/MRs (combined census is approximately 2,037) | serving approximately 13,136 persons |
| Georgia | 1 developmental services institution and 4 regional facilities for various consumers (combined census for DD/MR is approximately 1660) | 1 private ICF/MR (census is approximately 110)           | serving approximately 25,143 persons |
| Iowa    | 2 hospital schools (combined census is approximately 670)  | 2,566 bed total  | Yes - number unknown                 |

<sup>1</sup>/This chart reflects only the Developmentally Disabled populations in the referenced states, and does not include any data relating to individuals with other disabilities, including persons suffering from mental illness.

| State      | Institution   | ICF/MR  | Community Based Care  |
|------------|---|---|---|
| Louisiana  | 3 residential centers (combined actual census of 1,746) | none  | none  |
| Michigan   | 2 institutions (combined census is approximately 278)   | No private ICF/MRs  | Adult Foster Care (approximately 2,521 beds)  |
| New Mexico | None  | combined census is approximately 275  | serving approximately 2,250 persons   |
| Montana    | 2 facilities (combined census is approximately 123)     | census is approximately 8   | 100-150 served in "personal care facilities"<br><br>approximately 3,472 persons in remaining census |
| Nevada     | 2 institutions (combined census is 166)                 | ICF/MR (combined census 817 & represents service to 21% of DD population)<br><br><i>number of nursing home and ALF beds unknown</i> | Yes (represents service to approximately 79% of DD population)                                      |

| State          | Institution  | ICF/MR   | Community Based Care          |
|----------------|--|--|-------------------------------|
| New Jersey     | 7 institutions (combined census approximately 3,787)         | Unknown at time of publishing  | Unknown at time of publishing |
| New York       | 11 MR Institutions (combined census approximately 2,388)     | Unknown at time of publishing  | 30,000 persons                |
| North Carolina | 5 mental retardation centers (combined census 2,131 persons) | 4,000 bed total (represents half of the developmental services population) | Approximately 2,000 persons   |
| Utah           | 1 public ICF/MR (390 beds, 255 census)                       | 13 private ICF/MRs (combined census 575)                                   | Approximately 3,365 persons   |
| Texas          | 13 state schools (combined census approximately 5,332)       | 14,152 bed total   | Yes - but limited capacity    |



FEB 4 1999

IN THE  
**Supreme Court of the United States** ERK

OCTOBER TERM, 1998

TOMMY OLMSTEAD, Commissioner of the Department  
of Human Resources of the State of Georgia,  
RONALD C. HOGAN, Superintendent of Georgia Re-  
gional Hospital, Atlanta, and EARNESTINE PITTMAN,  
Executive Director of the Fulton County Regional  
Board,

*Petitioners,*

v.

L.C. and E.W., each by JONATHAN ZIMRING  
as guardian at litem and next friend,

*Respondents.*

On Writ of Certiorari to the  
United States Court of Appeals  
for the Eleventh Circuit

BRIEF OF THE NATIONAL CONFERENCE OF  
STATE LEGISLATURES, COUNCIL OF STATE  
GOVERNMENTS, NATIONAL GOVERNORS'  
ASSOCIATION, NATIONAL ASSOCIATION OF  
COUNTIES, U.S. CONFERENCE OF MAYORS,  
NATIONAL LEAGUE OF CITIES, INTERNATIONAL  
MUNICIPAL LAWYERS ASSOCIATION AND  
INTERNATIONAL CITY/COUNTY MANAGEMENT  
ASSOCIATION AS *AMICI CURIAE*  
SUPPORTING PETITIONERS

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*Amici Curiae*

### QUESTION PRESENTED

Whether the public services provisions of the Americans With Disabilities Act compel a State to provide treatment and habilitation for mentally disabled persons in a community placement, when appropriate treatment and habilitation can also be provided to them in a state institution.



## TABLE OF CONTENTS

|  | Page |
|--|------|
| QUESTION PRESENTED .....   | i    |
| TABLE OF AUTHORITIES .....   | iv   |
| INTEREST OF THE <i>AMICI CURIAE</i> .....  | 1    |
| STATEMENT .....  | 2    |
| SUMMARY OF ARGUMENT .....  | 5    |
| ARGUMENT .....   | 7    |
| THE COURT OF APPEALS' HOLDING IM-<br>POSES A DEINSTITUTIONALIZATION MAN-<br>DATE THAT EXCEEDS THE SCOPE OF THE<br>ADA'S PUBLIC SERVICES PROVISIONS ..... | 7    |
| A. ADA § 12132 Does Not Impose An Integration<br>Mandate on State Mental Health Agencies .....   | 8    |
| B. As Applied To State Mental Health Agencies,<br>The Attorney General's Integration Regulation<br>Is Not A Reasonable Interpretation of § 12132..       | 13   |
| CONCLUSION .....   | 21   |
| APPENDIX .....   | 1a   |

## TABLE OF AUTHORITIES

| Cases  | Page          |
|--|---------------|
| <i>Alexander v. Choate</i> , 469 U.S. 287 (1985) .....   | 11            |
| <i>Atascadero State Hospital v. Scanlon</i> , 473 U.S. 234 (1985) .....  | 21            |
| <i>Chevron, U.S.A., Inc. v. NRDC, Inc.</i> , 467 U.S. 837 (1984) .....   | 6, 9, 14, 20  |
| <i>Clark v. Cohen</i> , 794 F.2d 79 (3d Cir.), <i>cert. denied</i> , 479 U.S. 962 (1986) .....                     | 18            |
| <i>Gregory v. Ashcroft</i> , 501 U.S. 452 (1991) .....   | 20-21         |
| <i>Helen L. v. DiDario</i> , 46 F.3d 325 (3d Cir.), <i>cert. denied</i> , 516 U.S. 813 (1995) .....                | 13            |
| <i>Kathleen S. v. D.P.W.</i> , 10 F. Supp. 2d 460 (E.D. Pa. 1998) .....  | 7             |
| <i>Lau v. Nichols</i> , 414 U.S. 563 (1974) .....  | 11            |
| <i>Lorillard v. Pons</i> , 434 U.S. 575 (1978) .....   | 19            |
| <i>Merrill Lynch, Pierce, Fenner &amp; Smith v. Curran</i> , 456 U.S. 353 (1982) .....                             | 19            |
| <i>Myers v. Hose</i> , 50 F.3d 278 (4th Cir. 1995) .....   | 13            |
| <i>Motor Vehicle Manufacturers Ass'n v. State Farm Mut. Auto Ins. Co.</i> , 463 U.S. 29 (1983) .....               | 20            |
| <i>P.C. v. McLaughlin</i> , 913 F.2d 1033 (2d Cir. 1990) ..  | 18, 18-19     |
| <i>Pennhurst State School &amp; Hospital v. Halderman</i> , 465 U.S. 89 (1984) .....                               | 21            |
| <i>Phillips v. Thompson</i> , 715 F.2d 365 (7th Cir. 1983) .....   | 18            |
| <i>Ricks v. Xerox Corp.</i> , 877 F. Supp. 1468 (D. Kan. 1995), <i>aff'd</i> , 96 F.3d 1453 (10th Cir. 1996) ..... | 18            |
| <i>United States v. Board of Comm'rs of Sheffield County</i> , 435 U.S. 110 (1978) .....                           | 19            |
| Statutes & Regulations   |               |
| 28 C.F.R. § 35.130(d) .....  | 13-14, 14     |
| 42 U.S.C. § 12101(a)(8) .....  | 12            |
| 42 U.S.C. § 12111(9) .....   | 12            |
| 42 U.S.C. § 12112(5) .....   | 12            |
| 42 U.S.C. § 12132 .....  | <i>passim</i> |
| 42 U.S.C. § 12134 .....  | 7, 18         |

## TABLE OF AUTHORITIES—Continued

| Other Authorities   | Page              |
|---|-------------------|
| <i>The American Heritage Dictionary Of The English Language</i> (3d ed. 1992) .....   | 9                 |
| Richard G. Frank & Laura L. Morlock, <i>Managing Fragmented Public Mental Health Services</i> (1997) .....  | 4, 8              |
| James L. Gibbons, <i>Mental Disorders and Their Treatment</i> , 23 <i>The New Encyclopedia Britannica</i> 859 (15th ed. 1993) .....   | 15                |
| H.R. Rep. No. 485, 101st Cong., 2d Sess. (1990), reprinted in 1990 U.S.C.C.A.N. 267 .....   | <i>passim</i>     |
| Theodore Lutterman, et al., <i>Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results Fiscal Year 1990</i> (1993) .....  | 2, 8              |
| NASMHPD Research Institute, <i>Number of Clients of SMHA-Operated &amp; Funded 24 Hour Hospital Care Services</i> (December 1996) (accessible at <a href="http://www.nasmhpd.org/nri/CLI_T1.HTM">www.nasmhpd.org/nri/CLI_T1.HTM</a> ) .....                                       | 3, 4, 11          |
| NASMHPD Research Institute, <i>State Mental Health Agency Profile System Highlights, Closing and Reorganizing State Psychiatric Hospitals: 1996</i> (November 1996) (accessible at <a href="http://www.nasmhpd.org/nri/SHSP_RPT.HTM">www.nasmhpd.org/nri/SHSP_RPT.HTM</a> ) ..... | 3                 |
| Nondiscrimination on the Basis of Disability in State and Local Government Services, Final Rule, 56 Fed. Reg. 35694 (1991) .....  | 16-17, 17, 18, 19 |
| Nondiscrimination on the Basis of Disability in State and Local Government Services, Proposed Rule, 56 Fed. Reg. 8538 (1991) .....  | 18                |
| Jay W. Spechler, <i>Reasonable Accommodation: Profitable Compliance with the Americans with Disabilities Act</i> (1996) .....   | 13                |
| E. Fuller Torrey, M.D., <i>Out Of The Shadows—Confronting America's Mental Illness Crisis</i> (1997) .....  | 11                |



## INTEREST OF THE *AMICI CURIAE*

*Amici* are organizations whose members include state, county, and municipal governments and officials throughout the United States.<sup>1</sup> *Amici* have a compelling interest in legal issues that affect state and local governments.

The provision of mental health care has long been a core state function. The States, the principal providers of such care, are committed to deinstitutionalization. Administering state mental health programs is, however, an extraordinarily complex task requiring planning and allocation of resources between various levels of state and local government and social services agencies. Providing community placements is especially difficult because of the highly fragmented nature of funding sources, medical care and support service providers.

The court of appeals held that "the ADA imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to that patient's needs." Pet. App. 21a. This holding exacerbates the already difficult task of administering state mental health programs. It is premised on the erroneous conclusion that a State's failure to provide such a placement to any mentally disabled patient constitutes unlawful discrimination "by reason of disability" even when a State does not provide such

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<sup>1</sup> The parties have consented to the filing of this brief *amicus curiae*. Letters indicating their consent have been filed with the Clerk of the Court. Pursuant to Rule 37.3 of the Rules of this Court, *amici* state that no counsel for a party has authored this brief in whole or in part, and that no person or entity, other than *amici* or their members, has made a monetary contribution to the preparation or submission of this brief.

placements to the non-disabled. And it imposed this costly mandate without anything in the ADA, its legislative history, or the Justice Department's rule-making, which indicates that Congress or the Justice Department ever considered the complex issues raised by the deinstitutionalization of the mentally disabled.

Because of the importance of this issue to *amici* and their members, this brief is submitted to assist the Court in its resolution of the case.

### STATEMENT

The provision of care for the mentally ill has long been a core function of state government. "Since the 19th century, state governments have had the central responsibility for orchestrating mental health services, particularly for individuals with serious and persistent mental illnesses, and for poor persons experiencing mental illness." Theodore Lutterman, et al., *Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results Fiscal Year 1990* 4 (1993). It is also a function for which the federal government provides only a fraction of the funding. Statement of A. Kathryn Power, Director, Rhode Island Department of Mental Health, Retardation & Hospitals, to United States Civil Rights Commission (Nov. 13, 1998), reprinted at App. 1a-3a, at 3a.

Over the last thirty years, the States have engaged in extraordinary efforts to reform their mental health care programs through various measures, including deinstitutionalization. In 1970, the national average daily inpatient population of state and county mental hospitals approached 368,000 persons. *See id.* at 1a. Today, the inpatient population is less than 73,000.

*See id.* Moreover, "[i]n 1981, two-thirds of all state mental health agency expenditures were spent in state psychiatric hospitals." *Id.* By 1993, however, state spending on community health services exceeded spending on state hospitals. *Id.* at 1a-2a.

As further evidence of their commitment to deinstitutionalization, the States have closed thirty-seven mental hospitals in the 1990's with an additional eight hospitals slated to be closed in the immediate future. *Id.* at 2a. A large number of States have also downsized their hospitals or closed wards. *Id.*; *see also* NASMHPD Research Institute, *State Mental Health Agency Profile System Highlights, Closing and Reorganizing State Psychiatric Hospitals: 1996* (November 1996) (accessible at [www.nasmhpd.org/nri/SHSP\\_RPT.HTM](http://www.nasmhpd.org/nri/SHSP_RPT.HTM)).

As a result of the States' efforts, today only a very small portion of persons receiving state mental health services for serious mental illnesses are institutionalized. A recent NASMHPD survey, which received data from forty States in fiscal year 1995, indicates that the average daily census of hospitalized persons was 64,827. *See* NASMHPD Research Institute, *Number of Clients of SMHA-Operated & Funded 24 Hour Hospital Care Services* (December 1996) (accessible at [www.nasmhpd.org/nri/CLLT1.HTM](http://www.nasmhpd.org/nri/CLLT1.HTM)). These States, however, provided hospital care to 299,685 different persons during that year and mental health services of some type to more than 1.2 million adult persons.<sup>2</sup> *Id.*

<sup>2</sup> In fiscal year 1995, Georgia had an average daily population in its mental hospitals of 2,139. The State, however, provided hospital care to 22,163 different people and provided



As this data indicates, the States take seriously the importance of treating the mentally ill in community settings. Honoring this commitment, however, is not always feasible. The administration of state mental health programs is an extraordinarily complex task requiring planning and allocation of resources between such services as "pharmacotherapies, inpatient care, counseling, housing, vocational rehabilitation, and income support (e.g., Supplemental Security Income. . .)." Richard G. Frank & Laura L. Morlock, *Managing Fragmented Public Mental Health Services* 6 (1997). See also *Funding Sources and Expenditures of State Mental Health Agencies* at 31 (major state mental health agency programs "includ[e] state mental hospitals, other hospital inpatient services, community-based programs, and . . . support activities"); *id.* at 45 (listing various state mental health services).

Moreover, because of the variety of government programs and funding sources inherent with community-based treatment programs, resource allocation decisions may be delegated to "multiple [state] agencies . . . and hundreds of localities." *Managing Fragmented Public Mental Health Services* at 6. In addition, state mental health agencies must deal with numerous service providers including specialty mental health organizations, general medical providers, and human services agencies. *Id.* As one report explains, "[m]ental health policy makers view these complex arrangements as contributing to the fragmented financing and lack of organizational coordination of services for individuals with severe mental disorders." *Id.*

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mental health services of some type to 82,076 adult persons. NASMHPD Research Institute, *Number of Clients of SMHA-Operated & Funded 24 Hour Hospital Care Services*.

## SUMMARY OF ARGUMENT

1. The court of appeals erred in holding that in the case of mentally disabled persons being treated by a state mental health agency, "the ADA imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to that patient's needs." Pet. App. 21a. The plain language of the ADA's public services anti-discrimination provision, 42 U.S.C. § 12132, does not support the imposition of this costly mandate on state mental health programs.

Section 12132 provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." Georgia is not, however, excluding the mentally ill from participating in its community placement program because of their disability. Indeed, the State's provision of community-based treatment to a large number of mentally ill persons refutes any suggestion that it discriminates against the mentally disabled. Moreover, continued treatment in an institution of a mentally ill person who, though now deemed treatable in a community placement, was properly hospitalized but must wait her turn for a placement, does not establish that the State has discriminated "by reason of such disability." Such facts do not establish that the State has acted out of bias, prejudice, stereotype, or other irrational basis regarding a mentally ill person.

2. The Attorney General's integration regulation is a generally applicable rule that cannot be lawfully applied to require state mental health programs to provide community placements to all persons whose

treating professionals deem it appropriate. While the regulation may be a reasonable interpretation of Section 12132's anti-discrimination provision in other contexts, its application here exceeds the scope of the statute and is not entitled to deference. *See Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 842-43 (1984).

The legislative history makes clear that the ADA's prohibition of segregation was intended to address those instances where government agencies excluded persons with a disability from participating in a program offered to persons without disabilities. *See, e.g.*, H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 3, 50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 473. The court of appeals' assertion that "the denial of community placements to individuals with disabilities such as [respondents] is precisely the kind of segregation that Congress sought to eliminate," Pet. App. 12a, finds no support in the voluminous legislative history.

Furthermore, the Justice Department's rulemaking confirms that the integration regulation's purpose was to ensure the disabled equal access to government programs and services offered to the non-disabled. Requiring the government to provide the disabled with equal access to services and programs available to the non-disabled fulfills Section 12132's purpose of prohibiting discrimination "by reason of such disability." And such applications of the regulation do not unduly burden the government. The rulemaking's examples thus stand in stark contrast to the costly mandate imposed by the court of appeals.

## ARGUMENT

### THE COURT OF APPEALS' HOLDING IMPOSES A DEINSTITUTIONALIZATION MANDATE THAT EXCEEDS THE SCOPE OF THE ADA'S PUBLIC SERVICES PROVISIONS

The court of appeals held that in the case of mentally disabled persons being treated by a State's mental health agency, "the ADA imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to that patient's needs." Pet. App. 21a. The court grounded this duty on the Attorney General's rulemaking authority, *see* 42 U.S.C. § 12134, and the ADA's anti-discrimination provision. *Id.* § 12132. And it did so notwithstanding the absence of any showing that the State had discriminated against respondents by either denying them services it offers either to the non-disabled or to those with less serious mental disabilities.

Contrary to the court's statement that its "holding does not mandate the deinstitutionalization of individuals with disabilities," Pet. App. 21a, that is exactly what it does.<sup>3</sup> Indeed, the court's holding transforms the ADA from a prohibition of discrimination against the disabled into a prescription for a particular form of psychiatric care and a massive and costly mandate. As explained below, this result finds no support in the statutory text of the anti-discrimination provision of the ADA's Public Services Subchapter. *See* 42 U.S.C. § 12132. Nor is it sustainable as a valid exercise of the Attorney General's rulemaking authority. *See* 42 U.S.C. § 12134.

<sup>3</sup> *See, e.g., Kathleen S. v. D.P.W.*, 10 F. Supp. 2d 460 (E.D. Pa. 1998).



The treatment of the mentally ill has long been a state function, *Funding Sources and Expenditures of State Mental Health Agencies* at 4, and the States are the primary source of funding for such care. See *Managing Fragmented Public Mental Health Services*, at 5-6. Given the complexity of the task of administering state mental health programs, only a clear statement by Congress of its intent to impose a community treatment mandate would suffice to support such a costly and intrusive mandate. The ADA, however, contains no such statement. That the Justice Department's rulemaking reflects a total failure to consider the issue underscores the point. The judgment of the court of appeals should therefore be reversed.

**A. ADA § 12132 Does Not Impose An Integration Mandate On State Mental Health Agencies**

The ADA's anti-discrimination provision, which is generally applicable to public agencies, states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. While this provision is, as the court of appeals noted, a "broad prohibition on discrimination in public services," Pet. App. 7a, its language is not so open-ended as to justify the Attorney General's imposition of a duty to provide treatment of the mentally ill in a community placement whenever medical professionals deem it appropriate. See *id.* at 8a.

The lower court's willingness to defer to the "plain language" of the Attorney General's regulation, see *id.* at 7a, with nothing more than an afterthought as

to the meaning of Section 12132's language, see *id.* at 11a-12a, is contrary to this Court's command that in reviewing an agency's regulation, the first "question [is] whether Congress has directly spoken to the precise question at issue." *Chevron, U.S.A., Inc. v. NRDC, Inc.*, 467 U.S. 837, 842 (1984). As the Court has further explained, "[i]f the intent of Congress is clear, that is the end of the matter, for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43.

As Section 12132 makes clear, a qualified person's being "excluded from participation in or be[ing] denied the benefits of the services, programs, or activities of a public entity" must be "by reason of such disability." 42 U.S.C. § 12132 (emphasis added). In its ordinary meaning, a disabled person's "exclu[sion] from participation in" or "be[ing] denied the benefits of" governmental programs, *id.*, must be "because of" the person's disability. See *The American Heritage Dictionary Of The English Language* 1506 (3d ed. 1992) (defining idiom "by reason of" as "because of").

Georgia, like all States, provides community-based treatment services to a large number of mentally ill persons. That the State provides such placements refutes any suggestion that respondents' exclusion from participating in these programs was "by reason of" their disability. Indeed, due to the seriousness of their illnesses, both respondents were hospitalized initially for valid medical reasons. See Pet. 3; Pet. App. 2a-3a. Under the court of appeals' view, as soon as medical professionals deem a community placement to be appropriate, the State's continued treatment of them in an institution violates the ADA. The State is in violation of the ADA regardless of whether it

has the resources to move a plaintiff immediately into a community placement or can even find a placement.

The court of appeals' holding is erroneous and problematic. It improperly interjects the federal courts into the most complex and difficult questions of mental health treatment policy and resource allocation. And because the States' mental health programs do not have unlimited budgets, it is likely to be counter-productive.

Most significantly, where, as here, a State provides community placements to others with the same type of mental illness, it is impossible to square the court of appeals' holding with Section 12132's requirement that exclusion from the program be "by reason of such disability." And respondents' suit finds no further support in the plain meaning of Section 12132's text that "no qualified individual . . . shall, by reason of such disability, . . . be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

Respondents have made no showing that they were "subjected to discrimination" as the concept of discrimination is commonly understood. Continued treatment in an institution of a mentally ill person who, though now deemed treatable in a community placement, was properly hospitalized but must wait her turn for a placement, does not establish that the State has discriminated "by reason of such disability." Such facts do not establish that the State has acted out of bias, prejudice, stereotype, or other irrational basis regarding the mentally ill or a person with a particular type of mental illness. Indeed, any suggestion that Georgia discriminates against the mentally ill in institutionalizing patients is belied by FY 1995 data indicating that of the 22,163 persons which the

State institutionalized, the average daily patient count of its hospitals was 2,139. See NASMHPD Research Institute, *Number of Clients of SMHA-Operated & Funded 24 Hour Hospital Care Services*. See also E. Fuller Torrey, M.D., *Out Of The Shadows—Confronting America's Mental Illness Crisis* 207 (1997) (noting that Georgia's effective deinstitutionalization rate was 85.7%).<sup>4</sup>

Rather than analyze the meaning of Section 12132's language, the court of appeals invoked the ADA's "reasonable accommodation" principle applicable in

<sup>4</sup> In *Alexander v. Choate*, 469 U.S. 287 (1985), the Court rejected a challenge brought under Section 504 of the Rehabilitation Act to a state law which reduced Medicaid coverage for inpatient hospitalization. The suit alleged that the State's reduction of the number of days of coverage would have a discriminatory effect on the handicapped. See 469 U.S. at 289-90. Recognizing the importance of "keep[ing] § 504 within manageable bounds," *id.* at 299, the Court noted that "nothing in the pre- or post-1973 legislative discussion of § 504 suggests that Congress desired to make major inroads on the States' longstanding discretion to choose the proper mix of amount, scope, and duration limitations on services covered by state Medicaid." *Id.* at 307. The Court further explained that "[t]he State has made the same benefit . . . equally accessible to both handicapped and nonhandicapped persons, and the State is not required to assure the handicapped 'adequate health care' by providing them with more coverage than the nonhandicapped." *Id.* at 309.

The ADA's public services provision is also modeled on Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d. This provision has always focused on discrimination within a program. Thus, in *Lau v. Nichols*, 414 U.S. 563 (1974), the Court upheld an effects test for assessing the existence of discrimination. The Court, however, made clear that the relevant inquiry focused on the different treatment by the program of individuals on the basis of race, color, or national origin. *Id.* at 568.



the Act's employment provisions, *see* 42 U.S.C. §§ 12111(9), 12112(5), to assert that "[t]he ADA does not only mandate that individuals with disabilities be treated the same as persons without such disabilities." Pet. App. 12a-13a. According to the court of appeals, "[u]nderlying the ADA's prohibitions is the notion that individuals with disabilities must be accorded reasonable accommodations not offered to other persons in order to ensure that individuals with disabilities enjoy 'equality of opportunity, full participation, independent living, and economic self-sufficiency.'" *Id.* at 13a (quoting 42 U.S.C. § 12101(a)(8)).

The court of appeals' analysis ignores that Subchapter I's reasonable accommodation standard has the limited purpose of preventing employers from discriminating in the workplace against the disabled in favor of the non-disabled. *See* H.R. Rep. No. 485, 101st Cong., 2d Sess., pt. 2, 65-66 (1990) (reprinted in 1990 U.S.C.C.A.N. 347-48) ("reasonable accommodation requirement is best understood as a process in which barriers to a particular individual's equal employment opportunity are removed"). The provision's relevance to this case is that it, too, demonstrates that the ADA's purpose is to prevent discrimination against the disabled in favor of the non-disabled. State mental health programs, by definition, do not engage in such discrimination.

It is likewise an especially weak analogy given the very limited obligation which the standard imposes on employers. The standard only requires employers to provide an accommodation which is *reasonable*. Indeed, as the President's Committee on Employment of People with Disabilities has found, 88% of such accommodations cost the employer less than \$1000;

50% cost less than \$50, and 31% cost nothing. Jay W. Spechler, *Reasonable Accommodation: Profitable Compliance with the Americans with Disabilities Act* 7-8 (1996). The cost of compliance with Title I's reasonable accommodation standard is thus no where near what these community placements cost the State and local governments which implemented them—\$70,000 to 90,000. *See* J.A. 158-60; *cf. Myers v. Hose*, 50 F.3d 278, 283 (4th Cir. 1995); *Ricks v. Xerox Corp.*, 877 F. Supp. 1468, 1477 (D. Kan. 1995), *aff'd*, 96 F.3d 1453 (10th Cir. 1996).

The court of appeals' analogy to workplace discrimination ignores the complexity of the issue and the difficulty of administering mental health programs. If adopted, it would transform the ADA from a prohibition against discrimination into an affirmative and costly obligation to provide services irrespective of discrimination.<sup>5</sup>

**B. As Applied To State Mental Health Agencies, The Attorney General's Integration Regulation Is Not A Reasonable Interpretation of § 12132**

Ignoring its duty to parse Section 12132's prohibition of discrimination "by reason of . . . disability," the court of appeals asserted its obligation to defer to the Attorney General's integration regulation, 28

<sup>5</sup> For some patients, the court's mandate that "the ADA imposes a duty to provide treatment in a community setting—the most integrated setting appropriate to that patient's needs," Pet. App. 21a, might not be satisfied by moving them to group homes. Rather, as other litigation indicates, it may require the State to provide those who could reside in their homes with attendant care services if they could do so "with the appropriate level of monitoring" and care. Pet. App. 23a n.9. *See Helen L. v. DiDario*, 46 F.3d 325, 336-38 (3d Cir.), *cert. denied*, 516 U.S. 813 (1995).

C.F.R. § 35.130(d). *See* Pet. App. 7a. In the court's view, "the plain language of § 35.130(d) prohibits a state from providing services to individuals with disabilities in an unnecessarily segregated setting. . . . [W]here, as here, the State confines an individual with a disability in an institutionalized setting when a community placement is appropriate, the State has violated the core principle underlying the ADA's integration mandate." *Id.* at 8a.

The Attorney General's integration regulation is, however, a rule of general applicability. *See* 28 C.F.R. § 35.130(d) ("A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.") While the rule may well be a reasonable interpretation of the ADA's public services anti-discrimination provision in other contexts, *see, e.g., Chevron*, 467 U.S. at 844, its application here is not entitled to deference. Indeed, the court of appeals committed several fundamental errors in upholding the regulation's applicability to state mental health programs.

The court of appeals placed much stock in ADA Section 12134's grant to the Attorney General of rule-making authority to implement Section 12132's prohibition of discrimination. *See* Pet. App. 6a-9a. While the court engaged in a lengthy discussion of 28 C.F.R. § 35.130(d)'s undoubted purpose of remedying segregation of the disabled, *see* Pet. App. 9a-12a, its analysis of this case suffers from several critical flaws.

Most significantly, the court of appeals ignored that it is accepted and common medical practice to treat some severely mentally ill patients in hospitals. The

court's analysis further failed to recognize that even after a patient stabilizes to the point that they can be treated in a community setting, administrators must, in setting up a community placement, deal with funding constraints and the difficulty of finding adequate support services in the patient's community. *See* James L. Gibbons, *Mental Disorders and Their Treatment*, 23 *The New Encyclopedia Britannica* 859 (15th ed. 1993).

Moreover, contrary to the court of appeals' reasoning, analogies to the historic segregation of African Americans lead to the opposite conclusion of what the court drew—that application of the Attorney General's regulation in this context is not a reasonable interpretation of the ADA. The court approvingly referred to committee report language stating that "integrated services are essential to accomplishing the purposes of Title II . . . . Separate-but-equal services do not accomplish this central goal and should be rejected." Pet. App. 12a (quoting H.R. Rep. No. 485, 101st Cong., 2d Session, pt. 3, at 50, reprinted in 1990 U.S.C.C.A.N. at 473). The court, however, did not inquire as to what groups Congress was comparing.

There is no doubt that Congress intended this question to be answered by comparing the government's treatment of the disabled with the non-disabled, as the same committee report confirms. The report's subsequent paragraph explains that, while the ADA "do[es] not prohibit the existence of all separate services which are designed to provide a benefit for persons with disabilities, such as specialized recreation programs, the existence of such programs can never be used as a basis to exclude a person with a disability



from a program that is offered to persons without disabilities." H.R. Rep. No. 485, pt. 3, at 50, 1990 U.S.C.C.A.N. at 473 (emphasis added). See also *id.*, pt. 2, at 37, 1990 U.S.C.C.A.N. at 318-19 ("Many agencies of State and local government receive Federal aid and thus are currently prohibited from engaging in discrimination on the basis of disability. However, where there is no state law prohibiting discriminatory practices, two programs that are exactly alike, except for funding sources, can treat people with disabilities completely differently than others who don't have disabilities.").

The court of appeals' further assertion that "the denial of community placements to individuals with disabilities such as L.C. and E.W. is precisely the kind of segregation that Congress sought to eliminate," Pet. App. 12a, finds no support in the voluminous legislative history. Despite the size and importance of state mental health programs, the legislative history does not contain even a mention of the ADA's impact on them, let alone a statement indicating that Congress viewed the failure to provide a community placement as a form of actionable discrimination prohibited by Section 12132. And the court of appeals' reference to Congress's generalized findings, see Pet. App. 11a, is no substitute for a clear statement to this effect.

The Justice Department's comments on issuing the final rule implementing subtitle A of the ADA public services provisions, including 28 C.F.R. § 35.130(d), support this view. While stating that "[i]ntegration is fundamental to the purposes of the [ADA]" and that "[p]rovision of segregated accommodations and services relegates persons with disabilities to second-class status," the comment goes on to explain that

it would be a violation of this provision to require persons with disabilities to eat in the back room of a government cafeteria or to refuse to allow a person with a disability the full use of recreation or exercise facilities because of stereotypes about the person's ability to participate.

Nondiscrimination on the Basis of Disability in State and Local Government Services, Final Rule, 56 Fed. Reg. 35694, 35703 (1991).

The final rule contains additional statements which confirm that the integration regulation is limited to ensuring the disabled equal access to government services and programs offered to the non-disabled. Therein, the Department explained that it "is an important and overarching principle of the Americans with Disabilities Act" that "[e]ven when separate programs are permitted, individuals with disabilities cannot be denied the opportunity to participate in programs that are not separate or different." *Id.* The Department then provides the following example:

[I]t would not be a violation of this section for a public entity to offer recreational programs specially designed for children with mobility impairments. However, it would be a violation of this section if the entity then excluded these children from other recreational services for which they are qualified to participate when these services are made available to nondisabled children

• • • •

*Id.*

The Department's comments likewise contain no discussion of the integration rule's applicability to state mental health programs. This is a telling indication of the unreasonableness of interpreting the rule as mandating community placements for several reasons. The examples cited in the rulemaking—ac-

cess to cafeterias, exercise facilities, and recreational programs—involve services and programs provided to the non-disabled. Requiring the government to provide equal access to such facilities and programs thus fulfills Section 12132's purpose of ensuring that the disabled are not discriminatorily excluded from government programs "by reason of [their] disability." Nor, when applied to such activities and services, does the integration regulation unduly burden the government.

The rulemaking's examples thus stand in stark contrast to the costly mandate imposed by the court of appeals. There is good reason why neither the notice of proposed rulemaking, *see* 56 Fed. Reg. 8538 (1991), or the final rule, *see* 56 Fed. Reg. 35694, indicate that a state mental health program's failure to provide community placements for all mental health patients who are appropriately treated in such placements violates Section 12132's prohibition of discrimination. In exercising its authority under Section 12134 to promulgate regulations "consistent" with those promulgated under the Rehabilitation Act, 42 U.S.C. § 12134, the Department was undoubtedly aware that the overwhelming weight of authority rejected claims that the Rehabilitation Act (and its implementing regulations) imposed a duty to provide, in the most integrated setting possible, services that are unavailable to the non-disabled. *See, e.g., P.C. v. McLaughlin*, 913 F.2d 1033, 1041 (2d Cir. 1990); *Clark v. Cohen*, 794 F.2d 79, 84 n.3 (3d Cir.), *cert. denied*, 479 U.S. 962 (1986); *Phillips v. Thompson*, 715 F.2d 365, 368 (7th Cir. 1983).<sup>6</sup>

<sup>6</sup> As the Second Circuit explained in *P.C. v. McLaughlin*:

The "clearly established law" concerning § 504 indicates that its central purpose is to assure that handi-

It is thus quite remarkable that the court of appeals supported its community placement mandate by invoking the maxim that "where 'a Congress that re-enacts a statute voices its approval of an administrative interpretation thereof, Congress is treated as having adopted that interpretation, and this Court is bound thereby.'" Pet. App. 10a (quoting *United States v. Board of Comm'rs of Sheffield County*, 435 U.S. 110, 134 (1978)). As the Attorney General's rulemaking indicates, the Department itself recognized that the Rehabilitation Act did not authorize the promulgation of an integration requirement for agencies which do not provide services to the non-disabled. Congress is also "'presumed to be aware of [a] . . . judicial interpretation of a statute and to adopt that interpretation when it re-enacts a statute without change.'" *Merrill Lynch, Pierce, Fenner & Smith v. Curran*, 456 U.S. 353, 382 n.66 (1982) (quoting *Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978)). And it is also the case that "'where, as here, Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute.'" *Id.* (quoting *Lorillard*, 434 U.S. at 581).

As evidenced by the examples given in the Attorney General's ADA rulemaking, *see* 56 Fed. Reg. at 35703,

capped individuals receive "'evenhanded treatment'" in relation to the nonhandicapped. The Act does not require all handicapped persons to be provided with identical benefits. Rather, it seeks to ensure that handicapped individuals have an opportunity to participate in and benefit from programs receiving federal assistance.

913 F.2d at 1041 (internal citations omitted).



the Justice Department's interpretation of the integration regulation as imposing a mandate on state mental health programs to provide community placements marks a radical departure from Congress' understanding of the duties it was imposing in enacting ADA Section 12132. That the Justice Department has consistently taken this position in litigation is irrelevant, *see* Pet. App. 7a-8a, as the Department's interpretation imposes duties which exceed the scope of the statute. *See Chevron*, 467 U.S. at 842-43. Indeed, even if one could deconstruct the statute's text so as to authorize this application of the regulation, the Department's failure to provide any notice that the rule would be applied in a manner this costly and disruptive to the State's interests would justify its invalidation. *See Motor Vehicle Manufacturers Ass'n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983) ("an agency rule would be arbitrary and capricious if the agency has . . . entirely failed to consider an important aspect of the problem"). Thus even if the Attorney General has broad authority under ADA Sections 12132 and 12134 to determine whether a particular state practice constitutes discrimination "by reason of . . . disability," this application of the regulation is "so implausible," 463 U.S. at 43, that it is not entitled to deference.

To hold otherwise would transform a prohibition against discrimination into a federal judicial veto over resource allocation decisions that are fundamentally the province of the States' political branches. The court of appeals' holding works such a drastic alteration of the federal-state balance that, even if Congress can constitutionally impose this mandate on the States, it must provide a clear statement of its intent to do so. *See, e.g., Gregory v. Ashcroft*, 501 U.S. 452,

460-61, 464 (1991); *cf. Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 242 (1985); *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89, 99 (1984). Because Congress provided no such statement here, the courts cannot apply the integration regulation to require the States to provide community placements for all mental health patients for whom such treatment is deemed appropriate.

#### CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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February 4, 1999

## APPENDIX



## APPENDIX

[November 13, 1998]

OPENING STATEMENT OF  
A. KATHRYN POWER*DIRECTOR, RHODE ISLAND DEPARTMENT OF  
MENTAL HEALTH, RETARDATION  
& HOSPITALS*

Good afternoon. Thank you for the opportunity to provide testimony today. My name is A. Kathryn Power and I am the Director of the Department of Mental Health, Retardation & Hospitals in Rhode Island. I am also the immediate Past President of the National Association of State Mental Health Program Directors (NASMHPD), which represents all 50 state and 5 territorial state mental health agencies, and I am a member of NASMHPD's Board of Directors. Joining me is Jenifer Urff, J.D., NASMHPD's Director of Government Relations.

Let me begin by expressing my strong support for the purposes and goals of the Americans with Disabilities Act. This landmark law sends the clear message that discrimination against people with disabilities will no longer be tolerated. For people with psychiatric disabilities, this law provides critical protections to facilitate access to employment, housing, medical treatment and other services necessary to begin the process of recovery.

The last three decades have seen dramatic and progressive changes in the public mental health system. In 1970, nearly 368,000 people were inpatients in state and county psychiatric hospitals on any given day; today that number is less than 73,000. In 1981, two-thirds of all state mental health agency expendi-

tures were spent in state psychiatric hospitals; by 1993, spending for community mental health services surpassed spending in state hospitals.

Although these statistics are the result of a trend away from institutions and toward the development of community services that began in the 1950s, the process of deinstitutionalization has accelerated considerably over the last decade. During the 1990s, states closed 37 state hospitals—nearly three times as many closures than in the previous two decades combined. An additional 8 hospital closings are planned, and many states are downsizing hospitals or closing hospital wings.

Many factors contribute to this more recent and rapid deinstitutionalization process, including a growing consensus within the mental health field that, whenever feasible, people with mental illnesses should receive services in a community, rather than institutional, setting. The principle that services should be provided in the most integrated setting possible is supported by the values and professionalism of those who administer our public mental health system. In my own state of Rhode Island, we've been able to close our only state psychiatric hospital and have entered the era of community membership that focuses all services and supports toward people with mental illnesses through a process of recovery.

The public mental health system is committed to continuing the process of deinstitutionalization and we are proud of the enormous progress we have made over the last 40 years and, in particular, over the last decade. However, we are painfully aware of our shortcomings in providing necessary supports for those who have moved into the community. About one-third of all adults who are homeless have a mental

illness. People with mental illnesses are poorly served by a vocational rehabilitation system that often does not understand or adequately address mental disabilities, and the opportunity to be employed is only a distant dream for the vast majority of people with mental illnesses. Providers of services are often ill-equipped to offer the integrated services that are most effective in treating a growing number of people who have co-occurring mental illness and substance abuse disorders or the broader array of services needed to serve people with dual diagnoses of mental illness and HIV/AIDS.

Some of these shortcomings are the result of a critical lack of resources for community services. Although the federal government provides assistance to states through the Community Mental Health Services Block Grant, this funding provides only a fraction of community services funding in most states. However, other barriers to the transition from institutions to communities are also critical, including the stigma about mental illness that impedes the development of housing and employment opportunities, the economic impact of major systems change, and the presence of sustained leadership over time.

As the Department of Justice and others consider strategies for implementing the ADA in a way that furthers our shared goal of providing effective services in the community to people with mental illnesses, it is critical that we understand the complexities of these transitions and the unique nature of systems change and state systems. I appreciate being invited here today to testify before the Commission about this important issue, and I look forward to exploring these issues in more depth during the question-and-answer period. Thank you.



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**FILED**  
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CLERK

No. 98-536

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**IN THE  
SUPREME COURT OF THE UNITED STATES**

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October Term, 1998

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**TOMMY OLMSTEAD, Commissioner of the Department of  
Human Resources of the State of Georgia, et al.,  
Petitioners,**

**v.**

**L.C. and E.W., each by JONATHAN ZIMRING, as guardian ad  
litem and next friend,  
Respondents.**

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**ON WRIT OF CERTIORARI TO THE UNITED  
STATES COURT OF APPEALS FOR THE  
ELEVENTH CIRCUIT**

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**AMICI CURIAE BRIEF OF  
ADAPT, NATIONAL COUNCIL ON INDEPENDENT  
LIVING, AND TASH IN SUPPORT OF RESPONDENTS**

---

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## TABLE OF CONTENTS

|   | <u>PAGE</u> |
|---|-------------|
| TABLE OF AUTHORITIES .....  | ii          |
| INTERESTS OF AMICI CURIAE .....   | 1           |
| SUMMARY OF ARGUMENT .....   | 2           |
| ARGUMENT .....  | 7           |
| I. Introduction .....   | 7           |
| II. Integration, Ending Segregation and Choice<br>Are the ADA's Fundamental Principles. ....  | 11          |
| III. Congress Knew That Americans with Disabilities<br>Have Been Discriminated Against and Kept<br>In Nursing Facilities and Other Isolated<br>Institutions. .... | 16          |
| IV. Disabled Persons Want An Opportunity and Real<br>Choice to Reside In the Community And<br>Not Be Unnecessarily Segregated. ....                               | 26          |
| Conclusion. ....  | 30          |



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## AMICI CURIAE BRIEF IN SUPPORT OF RESPONDENTS

### INTERESTS OF AMICI CURIAE

Amici are three national organizations composed primarily of persons with severe physical disabilities, including persons with spina bifida, cerebral palsy, muscular dystrophy, spinal cord injuries, multiple sclerosis, quadriplegia, paraplegia, head and brain injuries, poliomyelitis, amyotrophic lateral sclerosis, persons with sensory disabilities, and persons with cognitive, mental and developmental disabilities.<sup>1</sup>

Many of these persons have been unnecessarily segregated in nursing homes and other institutional facilities solely because they have disabilities, and many testified before Congress in support of ending unnecessary segregation.<sup>2</sup>

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<sup>1</sup> All parties have consented in writing to filing of this brief. Copies of the written consents are on file with the Clerk of the Supreme Court. Pursuant to 37.6 of the Supreme Court rules, none of the parties authored this brief in whole or in part and no one other than the amici or counsel contributed money or services to the preparation and submission of this brief.

<sup>2</sup> See *infra*, nn 32-38. Because other amici will discuss discrimination faced by people with developmental disabilities and mental disabilities, the present amici will focus on persons who have severe physical disabilities who are unnecessarily segregated in institutional facilities.

ADAPT, National Council on Independent Living ("NCIL") and TASH have a long history and record of enforcing the civil rights of people with disabilities, including the integration of disabled people into all aspects of society. They were key organizations that participated in the political and legislative process to pass the 1990 Americans With Disabilities Act, 42 U.S.C. § 12101 et seq., the civil rights statute for disabled persons, as well as the Fair Housing Act Amendments of 1988, 42 U.S.C. § 3604 et seq., and amendments to Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq.<sup>3</sup>

### Summary of Argument

The Court's decision in the present case will have significant ramifications for people with severe physical disabilities who are unnecessarily in nursing facilities and other institutions. As Attorney General Janet Reno stated in May, 1998,

[w]e believe that states have an obligation to provide services to people with disabilities in the most integrated setting appropriate to their needs.... Many individuals with disabilities are being placed in

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<sup>3</sup> They have been plaintiffs in numerous cases including, inter alia, ADAPT v. Skinner, U.S. Department of Transportation, 867 F.2d 1471, 881 F.2d 1184 (3d Cir. 1989), filed an amici curiae brief in Vacco, et al. v. Quill, et al., 117 S.Ct. 2293 (1997), and two currently are plaintiffs in ADAPT, et al. v. HUD, No. 98-1308 (3<sup>rd</sup> Cir. 1998)(pending).

nursing homes or other institutional settings even when they don't really need to be there.<sup>4</sup>

Throughout the country, community-based programs exist and could be used to prevent such unnecessary segregation. In addition to ending such segregation, these community-based programs often cost significantly less than the cost in the institutions. Helen L. v. DiDario, 46 F.3d 325, 332- 33 and 335 (3rd Cir. 1995), cert. denied, 116 S. Ct. 24 (1995), sub nom. Secretary of DPW of Pa. v. Idell S. ("ADA and its attendant regulations clearly define unnecessary segregation as a form of illegitimate discrimination against the disabled... [and that the] ADA is intended to insure that qualified individual receives services in a manner consistent with basic human dignity rather than a manner which shunts them aside, hides and ignores them").

Congress enacted the ADA not in a vacuum but with the benefit of years' worth of experience with the Rehabilitation Act of 1973, 29 U.S.C. § 794. In 1983, ten years after the Rehabilitation Act had been enacted, the United States Commission on Civil Rights noted "the ill effects of segregation," pointing out that:

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<sup>4</sup> Reprinted in National Conference of State Legislatures, Personal Assistance Services for People with Disabilities, 24 State Legislative Report at 1 (Jan. 1999)(emphasis added).



'Institutions serve two central purposes. First, they segregate disabled people from the community; and second they provide convenience for administrators....

'As vehicles of administrative convenience, they are ... successful....'

Institutionalization almost by definition entails segregation and isolation.... Indeed, a desire to segregate handicapped people from the rest of society prompted the development of residential institutions.<sup>5</sup>

Congress intended to "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1)(emphasis added). Following the Commission on Civil Rights, Congress explicitly found that "historically, society has tended to isolate and segregate" disabled persons. 42 U.S.C. § 12101(a)(2)(emphases added). One of Congress' explicit Findings was that discrimination persisted in the "institutionalization" of people with disabilities and that "segregation" of disabled people "continues to be a serious and pervasive social problem." *Id.* at 12101(a)(2) and (3)(emphases added). Congress did not intend for segregation and institutionalization to be the status quo; the ADA was intended to correct the legacy of discrimination. The

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<sup>5</sup> United States Commission on Civil Rights, Accommodating the Spectrum of Individual Abilities 33 and 34 (1983)(emphasis added)(quoting Bowe, Handicapping America).

Congressional national mandate would eliminate this discrimination against people with disabilities.

Petitioners want to reverse what Congress mandated and to go back to an "equal but separate" standard, where disabled people are forced to accept services in unnecessarily segregated and institutionalized settings. Petitioners urge this standard even when they recognize that the community is an appropriate setting for services. Brief of Petitioners at Question Presented and passim.

Despite Petitioners' repeated assertions, this case is not about the bogus "deinstitutionalization" codeword.<sup>6</sup> Brief of Petitioners at 38. Congress neither required, nor suggested, that the ADA mandates "deinstitutionalization."<sup>7</sup> Nor does the ADA require closure of any institution.<sup>8</sup> Nor does this case present the issue of what services are

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<sup>6</sup> The Helen L. decision has not resulted, despite Petitioners' fears, in "massive deinstitutionalization." In fact since the decision, the nursing home population has increased by more than 4,400 individuals. Pennsylvania Department of Public Welfare, Office of Budget (1998).

<sup>7</sup> This case is not about per se institutionalization or segregation, but about whether Congress recognized unnecessary segregation and unnecessary institutionalization as one form of discrimination to be ended. Throughout Brief of Petitioners, it is clear that they challenge a ban on segregation and institutionalization even when, for specific people, they are unnecessary.

<sup>8</sup> Rather, the ADA mandates that each person with a disability be evaluated individually, rather than a "one-size-fits all," as

necessary. The ADA does not mandate the provision of any services whatsoever.<sup>9</sup> However, once a public entity decides to offer the service, then, and only then, must the service be offered, if appropriate to the individual, in an integrated setting, and if the provision of the service does not present an undue hardship or fundamental alteration.

What this case is about is ending unnecessary segregation and institutionalization; it is about finally achieving integration for disabled people. It is about a real choice to live in the community.<sup>10</sup> If a particular disabled person meets the eligibility criteria for services in an

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Petitioners suggest. Brief of Petitioners at 2.

<sup>9</sup> There is no question that a state's long-term health care services, whether provided in an institution or in the community and whether funded by Title XIX of the Social Security Act or with a state's own funds, are all part of states' seamless "services, programs and activities." See Pennsylvania Department of Corrections v. Yeskey, 118 S.Ct.1952 (1998). The mix of long-term health care services is clearly left to each state. The ADA requires only that the services and programs are provided in a "setting" that is "most integrated," when appropriate, after an individual's needs are reviewed.

<sup>10</sup> Petitioners want to usurp the decision-making of people with severe physical disabilities regarding their integration into society and want to compel them to accept services in unnecessarily isolated and separate settings.

Your amici recognize that there are some persons with disabilities who may believe that an institutional setting is appropriate to meet their needs. We are not arguing the ADA intended that whenever "the most integrated setting" is appropriate, that the person must accept integrated services, but only that services in integrated settings must, at least, be offered. We believe that at a minimum, Congress and the ADA require that a choice be offered - including integrated residential settings.

integrated setting and if a public entity could offer those services in a community setting without a "fundamental alteration," then a public entity that refuses to provide those services an integrated setting, but will provides them only in a segregated setting, would violate the ADA. Thus, this case is about a very fundamental American principle - whether disabled people, like other minorities, will continue to be unnecessarily segregated or will be integrated into their communities and society.<sup>11</sup>

## ARGUMENT

### I. Introduction

People with severe physical disabilities have been forced to live in institutional facilities not because they needed segregated settings, nor because such settings were appropriate -- since physical, mental and developmental disabilities are not contagious diseases, and since Petitioners acknowledge that the services and programs are and can be provided in the community.<sup>12</sup> Rather, public entities have segregated

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<sup>11</sup> Petitioners would not urge "equal but separate" services for blacks, women, or any other minority. The ADA and Congress intended to end the "second class" status of disabled persons. Nevertheless, Petitioners want to usurp the decision-making of people with severe physical disabilities regarding their integration into society.

<sup>12</sup>

Brief of Petitioners, passim.



people in institutions instead of providing them with integrated services in the community, because *historically* that was the way people with disabilities were kept out of sight and away from the public. Such segregation is both unnecessary and is also more costly.<sup>13</sup>

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<sup>13</sup> In 1981, Congress amended the Medical Assistance statute, Title XIX of the Social Security Act, 42 U.S.C. § 1396n, to provide for "Home and Community-Based Services," a medical assistance "waiver" program giving states a cost-effective, administratively non-burdensome process for moving persons from institutional to community settings. *Id.*, at 1396n(c)(2)(A), (D), (4)(A). Petitioners grossly misunderstand how this community waiver provision can be used to give disabled persons a choice to receive services in the community. Brief of Petitioners at 31-32. It is true that the Home and Community-Based waiver does not require an eligible individual receive services in the community "if the [person] preferred institutional care." *Id.* Title XIX is a federal reimbursement statute that reimburses states for their long-term care program for people with disabilities whether in institutions or the community. When states provide services in the community, the federal government via the "waiver" will reimburse the same percentage of federal funds for both community and institutional long-term care services, whether in a nursing home or in the community. Thus, there is no financial disincentive to the state in complying with "the most integrated setting" requirement.

The National Governors' Association recognized early on that "the waiver authority [would] give states greater flexibility to community-based delivery systems where they would serve as a more cost-effective alternative to nursing homes for those in need of long term care." National Governors' Association, Center for Policy Research, An Analysis of Responses to Medical Home and Community-Based Long-Term Care Waiver Program vii (1983).

Moreover, as a result of states opting to use Home and Community-Based waivers, there is no question that those states "have realized significant savings by offering services that allow people with disabilities to live in the community rather than in nursing homes or other institutions." National Conference of State Legislatures, Personal Assistance Services for People with Disabilities, 24 State Legislative Report at 2 (Jan. 1999)(emphases added).

Petitioners do not tell this Court that, in enacting the ADA, Congress recognized that the Rehabilitation Act had not fulfilled the "compelling need ... for the integration of persons with disabilities into the economic and social mainstream of American life,"<sup>14</sup> nor do Petitioners mention that the ADA was enacted to "break down barriers to the integrated participation of people with disabilities in all aspects of community life."<sup>15</sup> Rather, they pretend that the ADA did not recognize the shortcomings of the Rehabilitation Act.

Fourteen years ago, this Court stated, in addressing the Rehabilitation Act of 1973, 29 U.S.C. § 794, that discrimination against people with disabilities was "most often the product, not of invidious animus, but rather of thoughtlessness and indifference - of benign neglect." Alexander v. Choate, 105 S.Ct 712, 717 (1985).

Since the 1990 enactment of the ADA, the continued *unnecessary* segregation of people with disabilities in institutional nursing facilities can no longer be the result of "benign neglect."<sup>16</sup>

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<sup>14</sup> S. Rep. No. 116, 101st Cong. at 20 (1989)(emphasis added).

<sup>15</sup> H.R. Rep. No. 485 (III) at 49-50 (1990)(emphasis added), reprinted in 1990 U.S.C.C.A.N. at 472-73.

<sup>16</sup> Neither of the two respondents, LC and EW, require institutionalization. L.C. v. Olmstead, 138 F. 3d 893, 895, n.2 (11th Cir.

When public entities refuse to reallocate the same funds from overwhelmingly segregated settings to integrated settings, when public entities could in fact save funds by providing integrated services,<sup>17</sup> and when a public entity continues to allocate funds primarily in segregated facilities, that is *unnecessary* segregation and is not benign. The refusal to reallocate existing funds causes segregation and is deliberate. As Congress found, such discriminatory practices continue through "outright intentional exclusion" and "segregation." 42 U.S.C. § 12101(a)(5).

The ADA was supposed to be the clarion call to end unnecessary segregation. No longer would segregation be permissible when Americans with disabilities could, and would choose, to live

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1998). Neither did Idell Smith. Helen L., *supra*, 46 F.3d at 329, n.6. Thus, these three women were unnecessarily segregated and institutionalized.

<sup>17</sup> Amici emphasize that this case is not about increasing expenditures. To the contrary, states will save funds. See *infra*, n. 52. Unlike the reallocation of existing funds to community-based programs, there are other provisions of the ADA which, in fact, may require public entities to expend new funds to eliminate discrimination. See e.g., public entities must construct curb cuts when they resurface streets, 28 C.F.R. § 35.151(e), Kinney v. Yerusalum, 812 F. Supp. 548 (E.D. Pa. 1993), *aff'd*, 9 F.3d 1067 (3d Cir. 1993), *cert. denied*, 114 S.Ct. 1545 (1994); make new buses and subways accessible, 42 U.S.C. § 12142; and develop a paratransit system, 42 U.S.C. § 12143.

integrated in the community. Nevertheless, such segregation still persists and is the subject of the instant case.

Senator Lowell Weicker, an original sponsor of the ADA, told Congress the impact the ADA would have on segregation in institutional settings:

For years, this country has maintained a public policy of protectionism toward people with disabilities. We have created monoliths of isolated care in institutions.... It is that isolation and segregation that has become the basis of discrimination faced by many disabled people today. Separate is not equal. It was not for blacks; it is not for the disabled.<sup>18</sup>

## II. Integration, Ending Segregation and Choice Are the ADA's Fundamental Principles

The ADA is the anti-discrimination, civil rights statute for persons with disabilities. Congress, the Administration and people with disabilities understood, when the ADA was passed, that segregation

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<sup>18</sup> Hearing Before the Senate Committee on Labor and Human Resources and the Sub-Committee on the Handicapped, 101<sup>st</sup> Congress, 1<sup>st</sup> Session, 215 (1989)(emphases added). See also, Sen. Harkin "[f]or too long, individuals with disabilities have been excluded, segregated, and otherwise denied equal, effective and meaningful opportunity to participate in the economic and social mainstream of American life. It is time we eliminate these injustices." 135 Cong. Rec. S19801 (1989)(emphasis added). Rep. Miller, "It has been our unwillingness to see all people with disabilities that has been the greatest barrier to full and meaningful equality. Society has made them invisible by shutting them away in segregated facilities." 136 Cong. Rec. H2447(1990)(emphasis added).



and particularly unnecessary segregation of persons with disabilities would end. Now, less than ten years since its enactment, Petitioners want to eliminate one of the most fundamental aspects of the ADA -- integrating disabled persons, ending unnecessary isolation and discrimination, and giving people with disabilities a choice of settings where they will receive services. They can do so only by repeatedly mischaracterizing Congress' knowledge and intentions.

There is no doubt whatsoever that both houses of Congress intended that ending unnecessary segregation was integral to the ADA.

The definitive Committee in the House wrote:

The purpose of Title II is to continue to break down barriers to the integrated participation of persons with disabilities in all aspects of community life....While the integration of persons with disabilities will sometimes involve substantial short-term burdens, both financial and administrative, the long-range effects of integration will benefit society as a whole....<sup>19</sup>

The definitive Committee in the Senate wrote:

The Americans with Disabilities Act (ADA) will permit the United States to take a long-delayed but very necessary step to welcome individuals with

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<sup>19</sup> House Judiciary Committee. House of Representatives, Committee on the Judiciary Report No. 101-485 Part 3, pp.49-50 (101<sup>st</sup> Congress, 2d Sess.), May 15, 1990. (Emphases added).

disabilities fully into the mainstream of American society.<sup>20</sup>

At time of signing of ADA, President George Bush stated:

[t]his historic Act is the world's first comprehensive declaration of equality for people with disabilities....

This Act is powerful in its simplicity. It will ensure that people with disabilities are given the basic guarantees for which they have worked so long and so hard. Independence, freedom of choice, control of their lives, the opportunity to blend fully and equally into the right mosaic of the American mainstream.

And now I sign legislation which takes a sledgehammer to another wall, one which has for too many generations separated Americans with disabilities from the freedom they could glimpse, but not grasp.... Let the shameful wall of exclusion finally come tumbling down.<sup>21</sup>

At the same signing, Attorney General Dick Thornburgh stated that

"[t]his historical civil rights legislation seeks to end the unjustified

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<sup>20</sup> S. Rep. No. 116, 101st Cong., 1st Sess. 6 (1989)(reprinted in 1990 U.S.C.A.N. 267, 268; see H.R. Rep. No. 485 (I), 101st Cong., 2d Sess.24 (1990).

<sup>21</sup> Reprinted in National Council on Disability, Equality of Opportunity: The Making of the Americans with Disabilities Act at App. G (1997)(emphases added).

segregation and exclusion of persons with disabilities from the mainstream of American life...." *Id.*, at 3 (Emphasis added).<sup>22</sup>

Both by statute, 42 U.S.C. § 12182(b)(1)(B)(applicable to Title III private entities) and by federal regulation, 28 C.F.R. § 35.130(d)(applicable to Title II governmental entities), Congress and the ADA define as "discrimination" "services, programs, and activities" that a public entity does not offer "in the most integrated setting appropriate to the needs of qualified individuals with disabilities"(emphasis added). Petitioners challenge this integration requirement.<sup>23</sup> This regulation (and statute) ensures that people "interact with non-disabled persons to the fullest extent possible." 28

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<sup>22</sup> Attorney General Thornburgh had testified that "many persons with disabilities in this Nation still lead their lives in an intolerable state of isolation and dependence." S. Rep. No. 116, 101st Cong., 1st Sess. 7 (1989); H.R. Rep. No. 485 (II) at 32 (1990), reprinted in 1990 U.S.C.C.A.N. at 313.

<sup>23</sup> Petitioners constantly use "least restrictive treatment," a term used in the Developmental Disabilities Assistance and Bill of Rights Act 42 U.S.C. §§ 6000 et seq., even though neither the ADA's statute nor regulations ever use it. Brief of Petitioners, passim. Where Congress clearly intended the ADA to be a civil rights, antidiscrimination statute, the Developmental Disabilities Assistance and Bill of Rights Act was a funding statute that imposed no comparable antidiscrimination prohibitions. The ADA imposes no affirmative obligations on public entities to provide any services, but only prohibits discrimination once a public entity does provide services.

C.F.R. § Part 35, App. A. § 35.130(d). Often times, this can be achieved, where appropriate for an individual, only in the community.<sup>24</sup>

Petitioners would eliminate the Congressional goal of ending discrimination against people with disabilities in society's segregated settings, including nursing facilities.<sup>25</sup> They can do this only by belittling and ignoring the strong record which shows Congress was well aware of the unnecessary segregation and institutionalization of severely physically disabled persons in such settings and intended to end it.<sup>26</sup> Rather than complying with the ADA and offering services and programs in integrated settings, Petitioners attempt to seek to have this Court eviscerate the ADA, eliminating what Congress wanted explicitly to achieve.

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<sup>24</sup> Instead of complying, Petitioners want to be able to continue unnecessarily segregating and unnecessarily institutionalizing people with disabilities who neither require nor want to be segregated.

<sup>25</sup> There is no question that nursing facilities are segregated. "Because she is required to receive services in a nursing home, Idell S. has no contacts with non-disabled persons other than the staff of the nursing home and visits from her two children." *Helen L. v. DiDario*, 46 F.3d 325, 329 (3d Cir. 1995)(emphasis added).

<sup>26</sup> See infra, at nn. 32-38.



The needs of the person with a physical disability are usually quite objective, for example, needing assistance getting in and out of bed, assistance washing, taking medicine, eating. If there is only one setting where those needs can be met, then by definition it is the "most integrated." The issue of "most integrated" arises only when there are several settings where a person's needs could be appropriately met. When there are various settings, Congress intended that public entities had to make "the most integrated setting" available. Whether or not the person chooses "the most integrated setting" is up to the person with the disability, since there are persons who may believe that institutional programs are more appropriate to their needs. Petitioners want to perpetuate the unnecessary segregation, rather than offer eligible disabled persons the choice of integrated living.

### **III. Congress Knew That Americans with Disabilities Have Been Discriminated Against and Kept Unnecessarily "Out of Sight" In Residential Nursing Facilities and Other Isolated Institutions**

Seventeen years after the enactment of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, Congress found that people with disabilities still were "subjected to a history of purposeful unequal treatment...." 42 U.S.C. § 12101(a)(7). Congress certainly

knew that isolation, segregation, and institutionalization still existed in 1990. But Congress went even further, finding that

the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities to compete on an equal basis and to pursue those opportunities from which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity. 42 U.S.C. 12101(a)(9)(emphases added).

Congress knew that people with severe physical disabilities were both injured in institutions <sup>27</sup> and were unnecessarily segregated in nursing facilities. <sup>28</sup> Before the enactment of the ADA, Congress

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<sup>27</sup> See Martha Minow, Making All the Difference: Inclusion, Exclusion and American Law 175 (1990)("[T]he institution itself created circumstances of powerlessness and dehumanization.... The sheer fact of institutionalization stigmatized the person and, in many institutions, defined the individual as less than a person"); Susan Stefan, A Moment of Listening: Discrimination Against People with Psychiatric Disabilities and the Americans with Disabilities Act (1999)(Forthcoming)("Institutional living is defined not by size, but by the measure of control an individual retains over his or her own life and the most basic decisions about how to live it: when to go to sleep and get up in the morning, when and what to eat, the decorations of one's home and the choice of one's companions").

<sup>28</sup> Approximately 10.9% of the residents in nursing homes are under 65 years old. National Center for Health Statistics, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, An Overview of Nursing Homes and Their Current Residents: Data from the 1995 National Nursing Home Survey, Table 6 at 6 (January 23, 1997). In 1990, 4,231 people under the age of 25 were in nursing homes, Census Bureau Reports, Nursing Home Population: 1990 (CPH-L-137), and 57,017 people between the ages of 25 and under 50. Bureau of the Census, 1990 Census Population (STP 16).

held public forums throughout the country.<sup>29</sup> Many witnesses spoke of the segregation and injurious effects of nursing homes (and other institutional settings), referring "to the isolation, dependence and depression bred in nursing homes, as well as their enormous cost."<sup>30</sup>

Congress heard testimonies from people who had previously been institutionalized in nursing facilities and were now successfully living in the community. For example, Laura Cooper, a 32 year old practicing lawyer with multiple sclerosis who uses a motorized wheelchair for ambulation, testified about the severe isolation she experienced living in a nursing home because the state in which she lived did not have community programs.<sup>31</sup> Dr. William Spencer testified that "the absence of [community] services and support for independent living can make it nearly impossible to attain an autonomous lifestyle with control of one's own life. The alternative

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<sup>29</sup> Clearly hearing how disabled persons were treated prior to the ADA's enactment, Congress had a record from which to find that "historically society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2).

<sup>30</sup> Stefan, supra n.27.

<sup>31</sup> Hearings before H.R. SUBCOMMITTEE On Civil and Constitutional Rights, Committee on the Judiciary (10/11/89), reprinted in Arnold & Porter ADA Comm. Print. 1990 (28C) at \*1975-77. Ms. Cooper lives in her own apartment.

becomes chronic care in the hospital for the severely disabled or custodial placement in a nursing home."<sup>32</sup>

Ms. Janna Shishler testified that

on a crisp fall evening 10 years ago I became one of the continually expanding number of Americans with disabilities. My admission to the group took only a matter of seconds but the result has altered my life dramatically.... Since that night I have been a quadriplegic with no muscular function below my biceps. I was a 19 year old sophomore at Indiana University....

I believe that I am not an exception to the rule. The majority of persons with disabilities do not relish the thought of sitting day after day in a bedroom or nursing home. ... The [ADA] will allow many of the disabled who have heretofore been ostracized from society to become contributing members.<sup>33</sup>

One person testified about her 23 year old friend, Joe, who has lived in a nursing home since he had an accident at age 17. He was

placed in a nursing home one hour away from his friends and family.... [H]is self-esteem is not great. The battery for his motorized wheelchair is missing. No one will take responsibility for losing it....[H]e is unable to have his own telephone. He cannot have cable TV, either. He is again rooming with a man

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<sup>32</sup> Hearings before H.R. Subcommittee. on Select Education, Committee on Education and Labor. (8/28/89) reprinted in Arnold & Porter Comm. Print. 1990 (28A) at \*1514.

<sup>33</sup> Hearings before H.R. SUBCOMMITTEE. on Select Education, Committee on Education and Labor (10/6/89) reprinted in Arnold & Porter ADA Comm. Print. 1990 (28A) at \*1741.



who is in his nineties and is dying.... Joe was ready to get the wheels turning again so that he can moved on. Passage of the ADA will play a key role in his success.<sup>34</sup>

Mary Ella Linden, a 58 year old woman, testified about living in a nursing home for 23 years, where her parents had placed her because they considered her "too crippled to compete."

You see before you a woman who did not learn until August 10, 1987 that she had the strength to help with anything or to change her own outlook. My father had always chosen my path until his death in 1964. There was no alternative housing situation for my father to use for me after his death, but a nursing home. And so, at the age of 34, I was placed in a retirement home with my mother upon his death. And upon her death I was placed in the adjacent nursing home.... God only knows how many contributions society has missed because there were no provisions for the disabled to move about freely and determine their own lives. I pray that the ADA will be passed as soon as possible so that we may become another 'melted minority'.<sup>35</sup>

Eleanor Smith testified that

I reside in a nursing home right now. I am an active-minded person though physically disabled. I would have preferred to be able to live outside the nursing

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<sup>34</sup> Statement of Marcie Roth. Joint hearings before the U.S. Senate Subcommittee on the Handicapped of the Committee on Labor and Human Resources and H.R. SUBCOMMITTEE on the Select Education of the Committee on Education and Labor (9/27/88) reprinted in, Arnold & Porter ADA Comm. Print. 1990 (28B) at \*1110-11, 1113-14.

<sup>35</sup> Id., at \*988-89.

home in order that I might have independence to arrange my living style to meet many basic rights not currently available through a nursing home residence. These basic needs and rights include as follows: the right to maintain the privacy of telephone calls and mail and correspondence. The right to have some input into my general care and therapy. The right for a quiet surrounding ...that would enable me to do the personal tasks I would wish to do.<sup>36</sup>

Justin Dart told Congress that

[i]t is the status quo discrimination and segregation that are unaffordable, that are preventing persons with disabilities from becoming self-reliant and that are driving us inevitably toward the economic and moral disasters of giant, paternalistic welfare bureaucracies ... in unjust, unwanted dependency.... We appeal to you not for more welfare, not for more segregation in nursing homes....<sup>37</sup>

Despite the Congressional statutory Findings and Purposes, there are many people with physical disabilities for whom the ADA's anti-discrimination and "most integrated setting" are critical if they are to live in the community. For example, Idell Smith, 43, was paralyzed from the waist down due to meningitis. She used a wheelchair for

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<sup>36</sup> Id., at \*1161(emphasis added).

<sup>37</sup> Hearings before Joint Hearings before the U.S. Senate Subcommittee on the Handicapped of the Committee on Labor and Human Resources and H.R. SUBCOMMITTEE on the Select Education of the Committee on Education and Labor (7/18/89) reprinted in, Arnold & Porter ADA Comm. Print. 1990 (28B) at \*1326(emphasis added).

ambulation and needed assistance in getting in and out of bed. Helen L., supra at 328. She wanted to live at home with her two children instead of being unnecessarily segregated in a nursing facility. The state agreed that "although Idell S. is not capable of fully independent living, she is not so incapacitated that she needs the custodial care of a nursing home." Id. at 328. It was stipulated that "[t]he setting for the provision of attendant care services appropriate to the needs of Idell S. is in the community" and "[w]ith attendant care services in the community, nursing home care would not be appropriate for Idell S." Id., at 329, n.6. Nevertheless, and despite the enactment of the ADA, Pennsylvania refused to save \$10,000 per year by providing Idell Smith the same or similar services in the community that they paid for her in a nursing home. Id. at 329. Ms. Smith's situation parallels that of Respondents here when it is premised that the necessary services could be provided in either a residential or institutional setting.

Larry McAfee, a thirty-four year old man with quadriplegia as a result of an accident, was transferred from one institution to another "like a sack of potatoes" over a period of four years.<sup>38</sup> Georgia would not pay for community services but would pay only the costs of nursing

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<sup>38</sup> Peter Applebome, An Angry Man Fights to Die, Then Tests Life, N.Y. Times, Feb. 7, 1990, at A 1.

home care, where he lived for months, even though he was not ill, nor did he require any institutional care.<sup>39</sup> In the nursing home, he was told when to eat, sleep, and even what he could watch on his own video recorder.<sup>40</sup> Until he obtained the same services in the community that he had received in the segregated nursing home, he had requested the "right to die."

Jeff Gunderson has cerebral palsy. From age eighteen until he turned twenty-seven, he lived in a nursing home.<sup>41</sup> He wound up in a nursing home after his parents divorced and his mother could not lift him out of bed or care for him. "Gunderson's mother had little choice: she put her teenage son in a nursing home."<sup>42</sup> He was required to follow the same regimen as everyone else. He went to bed at 7 P.M., when his eighty year old roommate went to bed. His food was bland; he was tied to his bed; he was dragged into cold showers as punishment; he had to use the bathroom on a schedule convenient for the nurses or

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<sup>39</sup> Steven A. Holmes, Disabled People Say Home Care is Needed to Use New Rights, N.Y. Times, Oct. 14, 1990, at Sec. 1,2.

<sup>40</sup> Joseph Shapiro, Larry McAfee, Invisible Man: The Agonizing Fight to Prevent Legalized 'Suicide', U.S. News & World rep., Feb. 19, 1990, at 59.

<sup>41</sup> Joseph Shapiro, No Pity 237 (1993).

<sup>42</sup> Id., at 238.



they would put ice cubes down his pants.... On several occasions, Gunderson says he was given a suppository before sleep and, since he could not move by himself, he would spend the night lying in his own feces.... [D]ays were spent watching soap operas. 'Many times I wanted to kill myself,' he says. 'I planned it, too'.<sup>43</sup>

Mr. Gunderson now lives in a subsidized apartment and has an attendant who helps him dress, bathe, use the toilet, and eat -- the same daily activities performed in the nursing home. He also works, bowls, eats out, stays up late watching movies.

'I can go out and do things for myself.... I used to be a shy person because of all those years living in a nursing home'... 'I always said if I had to go back, I'd rather be six feet under'.<sup>44</sup>

Other people with severe physical disabilities have faced similar unnecessary segregation. An award winning magazine, which focuses exclusively on disability issues, devoted one issue to testimonies from disabled people who had lived in nursing homes.<sup>45</sup>

- ◆ People don't know there are kids in nursing homes. I was in a nursing home for thirteen years. I had to fight to get out. It was the beginning of my live at age 22. Claude H., Connecticut.

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<sup>43</sup> Id. See also, Timothy Diamond, Making Gray Gold: Narratives of Nursing Home Care (1992).

<sup>44</sup> Id. at 240

<sup>45</sup> You Choose, 6 The Mouth (Nov. 1995).

- ◆ Being in a nursing home, I was amazed at the number of people who were forced there because they had no services at home. Everything should be done to keep families together and keep people at home, not in nursing homes. Pat A., Michigan.
- ◆ I love being in a real home again. All my friends are welcome. I made my own curtains, do my own shopping, and I work as a volunteer. Dolores S., Missouri.
- ◆ Every day of every year, I wanted to go home. Norm B., Montana.
- ◆ For what Medicaid paid to that nursing home, I could have lived like a king. But it was like being a guest in a stranger's house. And the stranger doesn't want you there. Arthur A., Maine.
- ◆ I was put in a nursing home because my family didn't think I could manage on my own.... One staff guy beat up patients. I saw it.... Beverly H., Pennsylvania.
- ◆ I was existing. It got to the point there was no use. I was just going to die. I almost gave up. Jeanne L., New Mexico.
- ◆ I was forced to stay there. I had no other choice. You keep asking yourself, 'Is this America?' Jim B., Michigan.

These people represent many persons with physical disabilities who were and are unnecessarily and improperly segregated in nursing homes.<sup>46</sup> Each one of them did not have a choice -- each needed

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<sup>46</sup> Approximately 70 percent of persons 65 years and younger segregated in nursing homes are in nursing "homes" with 100 beds or more. Public reimbursements support 97 percent of all residents in nursing homes. National Center for Health Statistics, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, An Overview of Nursing Homes and Their Current Residents: Data from the 1995 National Nursing Home Survey, Table 6,

assistance getting in and out of bed, assistance eating, bathing, and toileting, which could easily be provided in an integrated setting. Without services, they could not survive.<sup>47</sup> Each wanted to live in the community. Each was receiving state funded services and the only issue was the setting - whether integrated in the community or segregated in an institution.

But for the ADA, these people would not be integrated. Petitioners would leave these people with no right to live in the community, "the most integrated setting appropriate for [their] needs" and would undo what Congress intended.

**IV. Disabled Persons Want An Opportunity and Real Choice to Reside In the Community And Not Be Unnecessarily Segregated**

People with physical disabilities do not want to be forced to accept segregated services and programs. At the minimum, they want the real choice of where they will receive these services. This is particularly applicable to persons with severe physical disabilities who, in order literally to survive, require assistance, whether it be in the form

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at 6 (January 23, 1997).

<sup>47</sup> Amici fully recognize that without these services, such as assistance getting in and out of bed, food preparation, toileting assistance, many people with severe disabilities would die.

of personal attendant services, such as assistance in getting out of bed, preparing food, assistance with toileting, or home health care. Without these services, many people with severe physical disabilities will end up hospitalized or worse.

One national survey of people with disabilities and their families found that

There is an overwhelming preference ... to remain in their own homes for as long as possible. The majority of people with disabilities do not live in institutions and are able to remain in their homes and communities. Most community-based long-term care is provided by family members and friends.<sup>48</sup>

When disabled persons and their families were asked where they wanted help with everyday activities, the results were quite stark: 47% strongly dislike having care provided in a nursing home or other residential settings; 48% strongly wanted assistance in the person's own home.<sup>49</sup>

Despite the "overwhelming preference" of Americans, "the majority of public spending ... remains devoted to institutional forms

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<sup>48</sup> Enid Kassner and Robert W. Bectel, Midlife and Older Americans with Disabilities: Who Gets Help? A Chartbook 21 (1998).

<sup>49</sup> Id. at 66.



of care,"<sup>50</sup> even though community-based services are generally less costly than residential nursing facilities and public entities would actually save funds. In a national comparison of institutional care versus home and community base care, the National Conference of State Legislatures found that:

the annual cost of institutional care for people with disabilities is more than double the average annual cost of providing home-and community-based services. In 1996, institutional care cost an average of \$94,348 per person, compared with \$14,902 per person for community-based services, with wide variation, depending on whether services include residential care. States across the country have realized significant savings by offering services that allow people with disabilities to live in the community rather than in nursing homes or other institutions.<sup>51</sup>

Petitioners want the right to tell people with disabilities that they must remain segregated and that the States should have the right to decide the setting where the disabled person will receive essential

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<sup>50</sup> Id. at 65. The fact that it is less expensive to provide services in the community compels the inference that it is a wilful lack of desire to rectify the situation.

<sup>51</sup> National Conference of State Legislatures, State Legislative Report- Personal Assistance Services for People with Disabilities, 24 State Legislative Report at 2 (Jan. 1999).

services.<sup>52</sup> States would never tell blacks or women where they must live or that they must receive services in segregated "blacks only" or "women only" settings. Assuming arguendo there are two "appropriate" settings, one integrated into the community and one segregated unnecessarily in an institution, States should never require a segregated setting; public entities should never be permitted to forcibly segregate when such segregation is not necessary.

By definition, if there are two appropriate settings, there are no justifiable reasons to compel segregation. If people with disabilities have no choice between receiving services in a segregated or integrated setting, then being forced to be institutionalized is a non-choice. Real choice requires that funds be comparably available for both settings, so the individual can decide where she or he wishes to receive the services without regard to the historical distribution of funds. States were not permitted to choose segregation for blacks as appropriate, nor are they permitted to choose segregation for disabled persons.

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<sup>52</sup> Brief of Petitioners at Question Presented and passim. Petitioners want the right to decide the setting in which the person with a disability will receive services even if the setting is unnecessarily segregated and unnecessary whatsoever.

### Conclusion

People with severe physical disabilities, like all Americans, want to control and direct their own lives, make decisions for themselves, be allowed to take risks and even fail, have opportunities to participate in all aspects of community life, and take responsibility for their actions, including responsibilities as part of their community.

For too long, disabled persons have been shut away, out of sight. How this Court decides the instant case and the ADA's "integration" requirement will decide whether or not many people with disabilities will have the choice to live in the community or be unnecessarily segregated.

Respectfully submitted,

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IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1998

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OLMSTEAD,

*Petitioner,*

v.

L.C. ex rel. Zimring, *et. al.*,

*Respondent.*

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On Writ of Certiorari to the  
United States Court of Appeals  
for the Eleventh Circuit

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**BRIEF AMICUS CURIAE OF  
THE NATIONAL COUNCIL ON DISABILITY  
IN SUPPORT OF RESPONDENTS**

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## TABLE OF CONTENTS

|   | Page |
|---|------|
| INTEREST OF AMICUS .....  | 1    |
| SUMMARY OF THE ARGUMENT .....   | 2    |
| ARGUMENT .....  | 5    |
| I. PROHIBITING UNNECESSARY ISOLATION<br>AND SEGREGATION OF INDIVIDUALS<br>WITH DISABILITIES IN TREATMENT AND<br>HABILITATION PROGRAMS WAS A KEY<br>COMPONENT OF THE ORIGINAL ADA<br>PROPOSAL DEVELOPED BY <i>AMICUS</i> ..... | 5    |
| A. The National Council on Disability and<br>the Origins of the ADA .....   | 5    |
| B. Conceptual Underpinnings of the Integration<br>Mandate of the ADA .....  | 8    |
| II. THE ADA PROHIBITS UNNECESSARY<br>ISOLATION AND SEGREGATION OF INDIVI-<br>DUALS WITH DISABILITIES IN TREATMENT<br>AND HABILITATION PROGRAMS .....  | 15   |
| A. The Statutory Language of the ADA .....  | 15   |
| B. The Legislative History .....  | 19   |
| C. ADA Regulations .....  | 25   |
| III. CONCLUSION .....   | 26   |



## TABLE OF AUTHORITIES

| Cases  | Pages           |
|--|-----------------|
| <i>Alexander v. Choate</i> , 469 U.S. 287 (1985) .....   | [13]            |
| <i>Bragdon v. Abbott</i> , 118 S.Ct. 2196 (1998) .....   | [4, 26]         |
| <i>Campbell v. Greer</i> , 831 F.2d 700 (7th Cir. 1987) .....  | [20]            |
| <i>Chevron, U.S.A., Inc. v. Nuclear Regulatory Defense Council, Inc.</i> , 467 U.S. 837 (1984) ..... | [4, 25, 26]     |
| <i>City of Cleburne v. Cleburne Living Center</i> , 473 U.S. 432 (1985) .....                        | [14]            |
| <i>Consumer Product Safety Comm'n v. GTE Sylvania, Inc.</i> , 447 U.S. 102 (1980) .....              | [20]            |
| <i>Green v. Bock Laundry Machine Co.</i> , 490 U.S. 504 (1989) .....                                 | [20]            |
| <i>Griffin v. Oceanic Contractors, Inc.</i> , 458 U.S. 564 (1982) .....                              | [20]            |
| <i>In re Marriage of Carney</i> , 598 P.2d 36 (Cal. 1979) .....                                      | [13]            |
| <i>Pennsylvania Dept. of Corrections v. Yeskey</i> , 118 S.Ct. 1952 (1998) .....                     | [4, 18, 19, 25] |
| <i>Sedima, S.P.R.L. v. Imrex Co.</i> , 473 U.S. 479 (1985) .....                                     | [19]            |

## STATUTES

|  |               |
|--|---------------|
| <i>The Americans with Disabilities Act of 1990</i> , 42 U.S.C. § 12101 <i>et seq.</i> (1994) ..... | <i>passim</i> |
| 29 U.S.C. § 781 (1994) .....   | [1, 5]        |
| 42 U.S.C. § 12101(a)(2) (1994) .....   | [3]           |
| 42 U.S.C. § 12101(a)(3) (1994) .....   | [4, 18]       |
| 42 U.S.C. § 12101(a)(7) (1994) .....   | [16]          |
| 42 U.S.C. § 12101(a)(8) (1994) .....   | [3, 16, 19]   |

|   | Pages       |
|---|-------------|
| 42 U.S.C. § 12101(a)(9) (1994) .....  | [17]        |
| 42 U.S.C. § 12101(b)(1) (1994) .....  | [4, 19]     |
| 42 U.S.C. § 12131(1)(A) (1994) .....  | [18]        |
| 42 U.S.C. § 12131(1)(B) (1994) .....  | [18]        |
| 42 U.S.C. § 12132 (1994) .....  | [4, 17, 18] |
| 42 U.S.C. § 12134(a) (1994) .....   | [3, 17, 25] |
| 42 U.S.C. § 12134(b) (1994) .....   | [3, 17, 25] |
| Pub. L. No. 98-201, tit. I, § 142, 98 Stat. 27 (1984)<br>(codified as amended at 29 U.S.C. § 781) ..... | [5]         |
| Pub. L. No. 100-630, tit. II, § 205(a), 102 Stat. 3310<br>(1988) .....                                  | [5]         |

## REGULATIONS

|                                    |             |
|------------------------------------|-------------|
| 28 C.F.R. § 35.130(d) (1998) ..... | [4, 25, 26] |
| 28 C.F.R. part 41 .....            | [17, 25]    |
| 28 C.F.R. § 41.51(d) (1998) .....  | [4, 17, 25] |

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| H.R. 4498, 100th Cong. 2d Sess. (1988) .....   | [7]              |
| S. 2345, 100th Cong., 2d Sess., 134 CONG. REC. 9379-9382 (1988) .....  | [7]              |
| H.R. REP. NO. 101-485 pt. 2 (1990) (Committee on Education and Labor), <i>reprinted in</i> 1990 U.S.C.C.A.N. 303 ..... | [17, 21, 22]     |
| H.R. REP. NO. 101-485 pt. 3 (1990) (Committee on the Judiciary), <i>reprinted in</i> 1990 U.S.C.C.A.N. 445 .....       | [20, 21, 22, 28] |
| S. REP. NO. 101-116 (1989) .....   | [17, 20, 21, 22] |
| 117 CONG. REC. 45,974 (1971) (statement of Rep. Vanik) .....   | [13]             |

## Pages

|  |              |
|--|--------------|
| 118 CONG. REC. 526 (1972) (statement of Sen. Percy).....   | [13]         |
| 134 CONG. REC. 9375 (1988) (statement of Sen. Weicker) .....   | [17, 21]     |
| 134 CONG. REC. 9599 (1988) (statement of Rep. Coelho) .....  | [7]          |
| 135 CONG. REC. 8505 (1989) (statement of Sen. Harkin) .....  | [17, 21, 22] |
| 135 CONG. REC. 8514 (1989) (statement of Sen. Kennedy) .....   | [24]         |
| 135 CONG. REC. 19800 (1989) (statement of Sen. Harkin) [21, 23]  |              |
| 135 CONG. REC. 19878 (1989) (statement of Sen. Chafee) .....   | [21]         |
| 136 CONG. REC. 10868 (1990) (statement of Rep. Edwards) .....  | [21, 22]     |
| 136 CONG. REC. 10872 (1990) (statement of Rep. Weiss) .....  | [21]         |
| 136 CONG. REC. 10877 (1990) (statement of Rep. Miller) .....   | [24]         |
| 136 CONG. REC. 11467 (1990) (statement of Rep. Dellums) .....  | [24]         |
| <i>Americans with Disabilities Act of 1988: Hearing on H.R. 4498 Before the Subcommittee on Select Education of the House Committee on Education and Labor, 100th Cong. (1988).....</i>      | [22, 23]     |
| <i>Americans with Disabilities Act of 1989: Hearing on S. 933 Before the Senate Committee on Labor and Human Resources and the Subcommittee on the Handicapped, 101st Cong. (1989) .....</i> | [24]         |

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| ROBERT L. BURGDOFF JR., THE LEGAL RIGHTS OF HANDICAPPED PERSONS: CASES, MATERIALS, AND TEXT (1980) .....   | [11]                 |
| Timothy M. Cook, <i>The Americans with Disabilities Act: The Move to Integration</i> , 64 TEMP. L. REV. 393 (1991) .....   | [16, 27]             |
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| NATIONAL COUNCIL ON DISABILITY, ACHIEVING INDEPENDENCE: THE CHALLENGE FOR THE 21ST CENTURY (1996) .....  | [27, 28]             |
| NATIONAL COUNCIL ON DISABILITY, EQUALITY OF OPPORTUNITY: THE MAKING OF THE AMERICANS WITH DISABILITIES ACT (1997) .....  | [7]                  |
| NATIONAL COUNCIL ON THE HANDICAPPED, ON THE THRESHOLD OF INDEPENDENCE (Andrea H. Farbman ed., 1988) .....  | [6, 7, 15, 17]       |
| NATIONAL COUNCIL ON THE HANDICAPPED, TOWARD INDEPENDENCE (1986) .....  | [5, 6, 7, 8, 14, 15] |
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No. 98-536

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IN THE  
**Supreme Court of the United States**  
 OCTOBER TERM, 1998

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OLMSTEAD,

*Petitioner,*

v.

L.C. ex rel. Zimring, *et. al.*,*Respondent.*


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On Writ of Certiorari to the United States Court of  
 Appeals for the Eleventh Circuit

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**BRIEF AMICUS CURIAE OF  
 THE NATIONAL COUNCIL ON DISABILITY  
 IN SUPPORT OF RESPONDENTS**

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**INTEREST OF AMICUS CURIAE**

This brief amicus curiae is filed, pursuant to consents of the parties filed with the Clerk,<sup>1</sup> on behalf of the National Council on Disability. The Council is an independent federal agency comprised of 15 members appointed by the President of the United States and confirmed by the U.S. Senate. Pursuant to its statutory mandate, 29 U.S.C. § 781 (1994), the Council is charged with reviewing federal laws, regulations, programs, and policies affecting people with disabilities to assess the effectiveness of such laws, regulations, programs, and policies in meeting the needs of individuals with

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<sup>1</sup> Pursuant to this Court's Rule 37.6, none of the parties authored this brief in whole or in part and no one other than amicus or counsel contributed money or services to the preparation and submission of this brief.

disabilities, and making recommendations to the President, the Congress, officials of federal agencies, and other federal entities, regarding ways to better promote equal opportunity, economic self-sufficiency, independent living, and inclusion and integration into all aspects of society for Americans with disabilities.

The Council plays a major role in developing disability policy in America, and, in 1986, first proposed the concept of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101 *et seq.* (1994), the statute at issue in this case. In 1988, the Council developed the original ADA bill that was introduced in the 100th Congress. Congress relied on and acknowledged the influence of the Council and its reports during congressional consideration and passage of the ADA; members and staff of the Council testified at congressional hearings on the legislation. Under its current statutory mandate, the Council is responsible for gathering information about the implementation, effectiveness, and impact of the ADA. The Council is thus intensely interested in ensuring that the ADA is implemented in a manner consistent with the purposes for which it was proposed. It is also uniquely qualified to provide the Court with information about the background and framing of the ADA, implementation of the Act, and other information concerning policy issues affecting persons with disabilities. The Council is also particularly concerned with and uniquely informed about the central issue in this case -- the integration of individuals with disabilities in the community, and, since the enactment of the ADA, has continued to assess and report on progress in regard to this critical issue.

### SUMMARY OF ARGUMENT

*Amicus* articulated the need for an Americans with Disabilities Act (ADA) and drafted the original ADA bill in response to statutory mission statements that directed it to assess the effectiveness of federal laws, regulations, programs, and policies in meeting the needs of individuals

with disabilities, and to make recommendations to the President and the Congress regarding ways to better promote inclusion and integration into all aspects of society for Americans with disabilities. Consequently, prohibiting unnecessary segregation and isolation of people with disabilities in various contexts, including state and local government facilities that provide treatment and habilitation services, was a central concern of the ADA proposal from its inception. This concern was reflected in express terms at each step of *amicus's* efforts to call for an ADA, to draft an ADA bill, to get it introduced in Congress in 1988, and to participate actively in efforts in 1989 and 1990 to revise the legislation and ultimately have it enacted.

*Amicus's* efforts in regard to the ADA, the conceptual underpinnings of the Act, the legislative history, the language of the ADA, and the relevant federal regulations are all in agreement regarding certain major principles that are critical to the present case: First, that *unnecessary isolation and segregation of persons with disabilities is a form of discrimination with serious negative effects*. This principle is recognized in the ADA statutory finding that "historically, society has tended to isolate and segregate individuals with disabilities, and ... such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." 42 U.S.C. § 12101(a)(2) (1994). Second, that *integration of people with disabilities is a basic and vital objective*. This principle is embraced in the ADA's identification of "full participation" as one of "the Nation's proper goals regarding individuals with disabilities." *Id.*, § 12101(a)(8).

Third, that *Title II requires state and local governments and their instrumentalities to provide services in the most integrated setting appropriate to the needs of individuals with disabilities*. This is accomplished in Title II provisions that direct the Attorney General to promulgate regulations to delineate forms of discrimination prohibited, which are to be consistent with a specific set of prior regulations. 42 U.S.C. §§ 12134(a) & (b)



(1994). The referenced regulations include a specific requirement that services are to be provided in "the most integrated setting appropriate." 28 C.F.R. § 41.51(d) (1998). Accordingly, the ADA Title II regulations promulgated by the Attorney General in July 1991 declare in clear and specific language: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (1998). Pursuant to the analysis in *Chevron, U.S.A., Inc. v. Nuclear Regulatory Defense Council, Inc.*, 467 U.S. 837, 844 (1984) and *Bragdon v. Abbott*, 118 S.Ct. 2196, 2209 (1998), these regulations qualify for judicial deference and are to be given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute.

Fourth, that *the prohibitions of discrimination in Title II of the ADA apply to all services, programs, and activities of state or local governments or their instrumentalities, including treatment and habilitation services for people with disabilities.* This principle is reflected in the plain meaning of Title II of the ADA's application to "the services, programs, or activities of a public entity," stated without any exception. 42 U.S.C. § 12132 (1994). It is underscored by the construction accorded these terms in *Pennsylvania Dept. of Corrections v. Yeskey*, 118 S.Ct. 1952 (1998). It is further buttressed by the ADA's stated purpose of providing a "comprehensive national mandate for the elimination of discrimination." 42 U.S.C. § 12101(b)(1) (1994). This principle is made manifestly clear in the congressional findings establishing the factual foundation for the ADA by the finding that "discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization," *id.*, § 12101(a)(3), and by unambiguous statements in the legislative history.

The plain language of the statute, its legislative history, its conceptual origins and pre-legislative history, the implementing regulations, and the applicable judicial precedents all point to the same conclusion -- that Title II of the ADA requires state and local governments and their instrumentalities to provide treatment and habilitation services

in the most integrated setting appropriate. In addition to all the legal signposts proclaiming such a requirement, *amicus* attests that it was, and is, good policy for individuals with disabilities and for the nation.

## ARGUMENT

### I. Prohibiting Unnecessary Isolation and Segregation of Individuals with Disabilities in Treatment and Habilitation Programs Was a Key Component of the Original ADA Proposal Developed by Amicus.

#### A. The National Council on Disability and the Origins of the ADA

The Americans with Disabilities Act originated as a proposal of *amicus* the National Council on Disability.<sup>2</sup> The statutory authorization of the Council expressly directed it to review Federal laws and programs affecting persons with disabilities and to assess the extent to which they "provide incentives or disincentives to the establishment of community-based services for handicapped individuals, promote the full integration of such individuals in the community, in schools, and in the workplace, and contribute to the independence and dignity of such individuals." Pub. L. No. 98-221, tit. I, § 142, 98 Stat. 27 (1984) (codified as amended at 29 U.S.C. § 781).

Based upon such assessment, the Council was charged, *inter alia*, with issuing, by February 1986, a report to the president and Congress analyzing federal laws and programs and presenting legislative recommendations to address shortcomings identified. *Id.* In response to this statutory mandate, the Council published a report to the president and Congress in January 1986. NATIONAL COUNCIL ON THE HANDICAPPED, TOWARD INDEPENDENCE (1986) (hereinafter

<sup>2</sup> The Council was initially named the National Council on the Handicapped. Its name was changed to the National Council on Disability in 1988. Pub. L. No. 100-630, tit. II, § 205(a), 102 Stat. 3310 (1988).

TOWARD INDEPENDENCE). In the report, the Council presented 45 legislative recommendations in 10 broad topic areas. The first recommendation was that

Congress should enact a comprehensive law requiring equal opportunity for individuals with disabilities, with broad coverage and setting clear, consistent, and enforceable standards prohibiting discrimination on the basis of handicap.

TOWARD INDEPENDENCE at 18.

The Council suggested that the proposed statute should be named the Americans with Disabilities Act. *See id.* at 18.

Subsequent recommendations in the report described what should be included in such a statute. *See id.* at 19B21. These recommendations spotlighted the importance of integration as an integral component of prohibiting and eliminating discrimination on the basis of disability; the Council proclaimed bluntly that "[d]iscrimination should be defined to include: a) Intentional exclusion; b) Unintentional exclusion; c) Segregation . . ." *Id.* at 19, Recommendation 3, and App., p. A-52 (same).

In describing the need for such legislation, *amicus* noted persisting discrimination, "in such critical areas as . . . institutionalization . . ." *Id.*, App. at A-3, quoting U.S. COMM'N ON CIVIL RIGHTS, ACCOMMODATING THE SPECTRUM OF INDIVIDUAL ABILITIES 159 (1983) [hereinafter ACCOMMODATING THE SPECTRUM]. Elsewhere in TOWARD INDEPENDENCE, *amicus* complained of "the unnecessary and expensive institutionalization" of individuals with disabilities. TOWARD INDEPENDENCE at 37. *Amicus* also called for "community-based independent living support services" as a cost-efficient alternative to large, isolated institutions. *Id.*, App. at G-3.

In the Council's 1988 follow-up report, ON THE THRESHOLD OF INDEPENDENCE, the Council fleshed out its concept of the ADA by publishing its own draft bill. NATIONAL COUNCIL ON THE HANDICAPPED, ON THE

THRESHOLD OF INDEPENDENCE 27B39 (Andrea H. Farbman ed., 1988). The draft bill included a finding that "segregation" is one of the "forms of discrimination." *Id.* at 27, § 2(a)(4). It also included the Council's statements of proposed congressional findings, including that "society has tended to isolate and segregate persons with disabilities" both historically and on a continuing basis; and that "discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization." *Id.* at 27, §§ 2(a)(2) & (3).

With a few changes not relevant here,<sup>3</sup> the Council's draft bill was introduced in the Senate April 28, 1988, and in the House of Representatives on April 29, 1988. S. 2345, 100th Cong., 2d Sess., 134 CONG. REC. 9379-9382 (1988); H.R. 4498, 100th Cong. 2d Sess.; *see* 134 CONG. REC. 9599-9600 (1988) (statement of Rep. Coelho). The ADA eventually was enacted in the following Congress, after numerous congressional hearings, and considerable negotiations, compromises, and revisions. As subsection II.A below indicates, the final language of the ADA enacted into law in 1990 retained the central focus on integration and the prohibition of unnecessary isolation and segregation in services for individuals with disabilities that had characterized the Council's version.

Based upon a great quantity of statistical information about the numbers of persons with disabilities receiving treatment and habilitation services in institutions and other settings, and cost data presented at various places in TOWARD INDEPENDENCE,<sup>4</sup> *amicus* decried "the costly institutionalization of persons with disabilities," and advocated for "community-based" services. *Id.*, App. at F-2, G-1. *See also id.* at 37 ("unnecessary and expensive institutionalization"). Synthesizing its cost analysis, *amicus* declared: "The question at hand, then, is not one of limited

<sup>3</sup> The nature of such changes and the circumstances surrounding the Council's decision to agree to the changes is described in NATIONAL COUNCIL ON DISABILITY, EQUALITY OF OPPORTUNITY: THE MAKING OF THE AMERICANS WITH DISABILITIES ACT 64-66 (1997).

<sup>4</sup> *See id.* App. at G-4, F-31, G-34 to G-40.



resources; it is one of orientation, priority reassessment, and funding reallocation to support community-based independent living services. *Id.*, App. at G-40.

At all times leading up to, during, and after developing its ADA proposal, the Council has understood integration as an inherent and indispensable element of prohibiting discrimination on the basis of disability.

#### B. Conceptual Underpinnings of the Integration Mandate of the ADA

The ADA did not suddenly emerge fully formed like Athena from the head of Zeus. The Council's crafting of the proposed legislation and later congressional revisions of the statutory language were informed by a conceptual framework that had developed over the years and decades that preceded it.

One of the earliest formulations of what has since come to be known as "disability rights" in America appeared in two law review articles published in 1966 by Jacobus S. tenBroek, a blind professor of political science and a distinguished legal and constitutional scholar. The first article outlined two basic approaches that a society can take regarding its citizens with disabilities: custodialism or integration:

The older custodial attitude is typically expressed in policies of segregation and shelter, of special treatment and separate institutions. The newer integrative approach focuses attention upon the needs of the disabled as those of normal people caught at a physical and social disadvantage. Jacobus tenBroek & Floyd W. Matson, *The Disabled and the Law of Welfare*, 54 CAL. L. REV. 809, 816 (1966).<sup>5</sup>

Noting that integration emphasizes people with disabilities' "potential for full participation as equals in the

<sup>5</sup> The U.S. Commission on Civil Rights has described this article as "seminal." *Accommodating the Spectrum* at 67.

social and economic life of the community" and "maximize[s] similarity, normality, and equality," tenBroek concluded that it was both the more equitable and the more practical option. *Id.* at 815, 816, 822, 824, 833B35. In the second article, tenBroek reiterated the endorsement of integration over custodialism, and went on to posit that people with disabilities have legal and constitutional rights and to argue that artificial barriers that keep such individuals from moving about in society, and thus prevent integration, are illegal. Jacobus tenBroek, *The Right to Live in the World: The Disabled and the Law of Torts*, 54 CAL. L. REV. 841, 842-43, 847-52, 912-18 (1966). TenBroek's ideas — the choice between custodialism and integration, and the legal system's role in protecting the rights of individuals with disabilities — accurately framed the issues that would later be addressed by what came to be termed "the disability rights movement." *See, e.g.*, JOSEPH P. SHAPIRO, *NO PITY* 5, 11, 13 (1993).

TenBroek envisioned unnecessarily segregated treatment institutions as the epitome of the evil that integration seeks to eliminate. The very term "custodialism" imparts a concept of unnecessarily segregated confinement. TenBroek described "policies of segregation and shelter, of special treatment and special institutions" as characteristic expressions of custodialism.<sup>6</sup> His concept of "the right to live in the world" is directly opposed to being forced to live outside the world, *i.e.*, in an unnecessarily isolated and segregated setting; and he specifically referred to unnecessary confinement of individuals with disabilities to "asylums" and "institutions" as violations of "personal liberty" and contrary to the policy of integrationism.<sup>7</sup> To address the prevalent overly custodial practices, tenBroek proclaimed "Integrationism the Answer."<sup>8</sup>

<sup>6</sup> Jacobus tenBroek & Floyd W. Matson, *The Disabled and the Law of Welfare*, 54 CAL. L. REV. 809, 816 (1966).

<sup>7</sup> Jacobus tenBroek, *The Right to Live in the World: The Disabled and the Law of Torts*, 54 CAL. L. REV. 841, 848-51, 847-48 (1966).

<sup>8</sup> *Id.* at 843.

In 1969, commentators suggested that the civil rights efforts of African Americans during the 1960s provided a possible model for people with disabilities in their efforts to achieve equality and integration in American society;<sup>9</sup> the critical focus upon requiring integration and eliminating segregation in this prototype is obvious. One of these publications dramatized the problems facing individuals with disabilities by describing a "Catalog of Horrors" featuring examples predominantly involving residential treatment facilities.<sup>10</sup> It went on to examine in some detail deprivations of rights resulting from "institutionalization" and "treatment in residential care facilities" for persons with mental retardation, "mental illnesses," and physical disabilities.<sup>11</sup> The author characterized some societal practices of relegating individuals with disabilities unnecessarily to such facilities as "put[ting] folks away in human warehouses."<sup>12</sup> As a remedy for such unnecessarily segregative practices, he advocated "normalization," a concept he defined as "to let the [person with a disability] obtain an existence as close to the normal as is possible" and called for it to be recognized as a legal right, citing tenBroek's writings.<sup>13</sup>

<sup>9</sup> RICHARD ALLEN, LEGAL RIGHTS OF THE DISABLED AND DISADVANTAGED 79B98 (1969); Leonard Kriegel, *Uncle Tom and Tiny Tim: Some Reflections on the Cripple As Negro*, 38 AM. SCHOLAR 412 (1969).

<sup>10</sup> Richard Allen, *Legal Rights of the Disabled and Disadvantaged* 2B3 (1969).

<sup>11</sup> *Id.* at 11, 13-20, 32-37, 48-54-55.

<sup>12</sup> *Id.* at 37 (internal quotation marks omitted).

<sup>13</sup> *Id.* at 7-8; *id.* at 54-55, referring to tenBroek, *The Right to Live in the World: The Disabled and the Law of Torts*, 54 CAL. L. REV. 841 (1966). The bracketed phrase "person with a disability" is substituted in the text for the phrase "handicapped person" used in the original. This change substitutes currently preferred terminology in accordance with the preference of most individuals with disabilities and consumer organizations of persons with disabilities. Similar changes, identified in brackets, are made throughout this brief; these substitutions impart no difference in meaning of quoted materials.

The first law school case book on the rights of people with disabilities, published in 1980, compiled cases and materials concerning discrimination involving almost every facet of life in the United States. ROBERT L. BURGDORF JR., *THE LEGAL RIGHTS OF HANDICAPPED PERSONS: CASES, MATERIALS, AND TEXT* (1980). The author summed up the "history of society's formal methods for dealing with [people with disabilities]" as "segregation and inequality," and observed that "[i]ndividuals with [disabilities] have faced an almost universal conspiracy to shunt them aside from the mainstream of society . . . . *Id.* at 51.<sup>14</sup> More than 100 pages of the book addressed the problems of unnecessary confinement of people with disabilities in state residential treatment facilities, including a section on community alternatives containing legal arguments for more integrated treatment and habilitation programs. *Id.* ch. 6, pp. 599-701 (1980).

The first comprehensive study by an agency of the U.S. government of discrimination faced by people with disabilities and the laws addressing discrimination occurred in 1983 with the U.S. Commission on Civil Rights' publication of its influential report *ACCOMMODATING THE SPECTRUM OF INDIVIDUAL ABILITIES*. This report provided both a summary of case law and a conceptual framework for understanding and addressing discrimination on the basis of disability. As one of its findings, the U.S. Commission on Civil Rights declared:

Historically, society has tended to isolate and segregate [people with disabilities]. Despite some improvements, particularly in the last two decades, discrimination against [persons with disabilities] continues to be a serious and pervasive social problem.

*Id.* at 159.

<sup>14</sup> See also Harlan Hahn, *Paternalism and Public Policy*, 20 Society No. 3, 36, 38 (March/April 1983) ("the history of disabled persons in America and elsewhere has been primarily a history of segregation and discrimination").



The Commission also found that discrimination against persons with disabilities "persists in such critical areas as ... institutionalization ...." *Id.* It identified 21 major issue areas, described as "not exhaustive," in which people with disabilities suffer discrimination. *Id.* at 165B68. Among these issues, the Commission included "Institutions and Residential Confinement" and included as particular problem areas "large-scale institutions," "[d]enormalization," and the "[a]bsence of community alternatives." *Id.* at 166. The Commission fleshed out its outline of such issues in a specific section titled "Institutionalization" in a chapter on types of discrimination on the basis of disability. *Id.* at 32-35. The Commission observed that "even the better institutions suffer the ill effects of segregation" and that "[i]nstitutionalization almost by definition entails segregation and isolation." *Id.* Indeed, the desire to segregate people with disabilities from the rest of society was an express goal for the development of such facilities. *Id.* at 33-34. The Commission concluded that, despite "the fact that most training, treatment, and habilitation services can be better provided to [persons with disabilities] in small community-based facilities rather than in large, isolated institutions," a great many individuals with disabilities "remain in segregative facilities." *Id.* at 34-35.

The Commission devoted a major section of a chapter of ACCOMMODATING THE SPECTRUM OF INDIVIDUAL ABILITIES to examining "The Costs and Benefits of Full Participation" including a specific section on "Institutionalization." *Id.* at 69-82; 78-79. Before beginning such analysis, the Commission cautioned, however, that cost considerations should not be a determinative criterion for laws prohibiting discrimination: "Many such initiatives, particularly civil rights laws proscribing discrimination against [people with disabilities] can be justified as a matter of simple equity and basic human rights to which cost should not be used as an excuse. Generally, the cost of eliminating discriminatory practices does not justify continuing to discriminate . . . ." *Id.* at 69. The Commission also noted that "[p]rojected costs have frequently proven to be overestimated and contrary to

common sense and practicality." *Id.* at 70. The Commission's conclusions about costs associated with treatment and habilitation facilities, however, are unequivocal:

Virtually all the relevant literature documents that segregating [people with disabilities] in large, impersonal institutions is the most expensive means of care. Evidence suggests that alternative living arrangements allowing institutionalized residents to return to the community can save money.

*Id.* at 78.

To respond to the various forms of discrimination, the Commission on Civil Rights called for the "full participation or total integration" of people with disabilities, and invoked federal nondiscrimination laws that "prohibit conduct, policies, and practices that currently exclude, segregate, or impede" people with disabilities. *Id.* at 68, 160, 164. The Commission quoted a 1979 decision in which the California Supreme Court observed that "[b]oth the state and federal governments now pursue the commendable goal of total integration of [persons with disabilities] into the mainstream of society." *In re Marriage of Carney*, 598 P.2d 36, 44 (Cal. 1979); see ACCOMMODATING THE SPECTRUM at 68.

In *Alexander v. Choate*, 469 U.S. 287 (1985), this Court, in applying Section 504 of the Rehabilitation Act of 1973, recognized the existence of "well-cataloged instances of invidious discrimination against [persons with disabilities]," in addition to discrimination against such individuals that is the product "of thoughtlessness and indifference -- of benign neglect." *Id.* at 295-96 and n. 12. The Court also quoted congressional declarations that discrimination against people with disabilities is one of America's "shameful oversights" that causes individuals with disabilities "to live among society 'shunted aside, hidden, and ignored ...'" *Id.* at 295-6 (quoting 117 CONG. REC. 45,974 (1971) (statement of Rep. Vanik); 118 CONG. REC. 526 (1972) (statement of Sen. Percy)). This vision of discrimination as the "shunting

aside" of people with disabilities makes it clear why segregation and unnecessary separation from the rest of society are the essential evils that disability nondiscrimination laws are designed to prohibit.

In separate opinions in *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985), five justices acknowledged the history of severe and "grotesque" discrimination visited upon people with mental retardation because of prejudice against them. *Id.* at 454 (Stevens, J., joined by Burger, C.J., concurring) ("history of unfair and often grotesque mistreatment" arising from "prejudice and ignorance"); *id.* at 461 (Marshall, J., joined by Brennan & Blackmun, JJ., concurring in part and dissenting in part) ("subject to a lengthy and tragic history of segregation and segregation that can only be called grotesque" (internal quotation marks and citation omitted)). In his partial dissent, Justice Thurgood Marshall also wrote of a "regime of state-mandated segregation and degradation." *Id.* at 462. He also observed that "[m]assive custodial institutions were built to warehouse the retarded for life," and that "lengthy and continued isolation . . . has perpetuated the ignorance, irrational fears, and stereotyping that long have plagued them." *Id.* at 462, 464.

This conceptual background, in which discrimination against people with disabilities was recognized as a serious problem, unnecessary segregation of people with disabilities was considered the essence of discrimination, and relegation of people with disabilities to unnecessarily isolated and segregated institutions was seen as an extreme form of such discrimination, colored the framing of the ADA proposal by *amicus* the National Council on Disability and the crafting and enacting of the legislation by the Congress. *Amicus's* proposal of an ADA was strongly influenced by this conceptual background, including, particularly, the U.S. Commission on Civil Rights' report ACCOMMODATING THE SPECTRUM OF INDIVIDUAL ABILITIES. In its TOWARD INDEPENDENCE report and its draft ADA bill, *amicus* incorporated the Commission's findings that "society has tended to isolate and segregate persons with disabilities," that

"discrimination against persons with disabilities persists in such critical areas as . . . institutionalization . . ."; and that "every day, people with disabilities encounter various forms of discrimination, including . . . segregation . . ." TOWARD INDEPENDENCE, App. at A-3; ON THE THRESHOLD OF INDEPENDENCE, at 27, §§ 2(a)(2), (3), & (4).

*Amicus* also quoted tenBroek's articulation of the distinction between "custodial" and "integrative" approaches to disability, TOWARD INDEPENDENCE, App. at A-2, and recounted the Commission on Civil Rights' conclusion that "government bodies at all levels of modern American society have, with relative consistency, chosen full participation as the desired objective for people with disabilities." *Id.*, citing ACCOMMODATING THE SPECTRUM 67-69.<sup>15</sup>

This societal objective was incorporated in *amicus's* proposed ADA bill in the form of a finding that "full participation" is one of "the Nation's proper goals regarding people with disabilities." ON THE THRESHOLD OF INDEPENDENCE, at 28, § 2(a)(7). In proposing the ADA, *amicus* was fully aware of the problem of unnecessarily segregated treatment and habilitation facilities and intended its legislative proposal to address this problem.

## II. The ADA Prohibits Unnecessary Isolation and Segregation of Individuals with Disabilities in Treatment and Habilitation Programs.

### A. The Statutory Language of the ADA

Although the details of the final provisions of the ADA as enacted by Congress vary in many respects from the

<sup>15</sup> In addition to discussing federal endorsements of the integrative or full participation approach, the Commission's report noted that many state laws incorporate similar language. *See id.* at 68 n.7. The integrative approach has been expressly adopted in United Nations declarations, in court decisions, and by the disability community and business leaders. *See, e.g., id.* at 68 n.69. *See also* Mark E. Martin, Note, *Accommodating the Handicapped: The Meaning of Discrimination Under Section 504 of the Rehabilitation Act*, 55 N.Y.U. L. REV. 881, 898-99 (1980).



original ADA proposal developed by *amicus*, *amicus* believes that the final statute is fully consistent with its original proposal in terms of prohibiting placement of individuals with disabilities in unnecessarily isolated and segregated treatment and habilitation programs. Relevant to the present issues, wording contained in *amicus's* proposed ADA bill appears verbatim in the final Act regarding the following:

- Identification of "full participation" as one of "the Nation's proper goals regarding individuals with disabilities"
- Recognition that "historically, society has tended to isolate and segregate individuals with disabilities"
- Finding that "discrimination against individuals with disabilities persists in such critical areas as . . . institutionalization"

42 U.S.C. §§ 12101(a)(8), (2), & (3) (1994).<sup>16</sup>

Another finding in the ADA derived word-for-word from *amicus's* draft bill concerns costs attributable to discrimination: "the continuing existence of unfair and

<sup>16</sup> A related finding is that individuals with disabilities are

a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society . . . .

*Id.* § 12101(a)(7).

Some commentators have argued that the ADA in effect creates a statutory requirement that government actions that segregate or otherwise disadvantage people because of disability should be subjected to strict judicial scrutiny similar to that applied to racial classifications. See, e.g., Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 433B39 (1991).

unnecessary discrimination . . . costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity." 42 U.S.C. § 12101(a)(9) (1994); ON THE THRESHOLD OF INDEPENDENCE, at 28, § 2(a)(8).<sup>17</sup>

Title II of the ADA, whose provisions apply in the current case, is very straightforward. It declares: (1) that "public entities" shall be prohibited from discriminating "by reason of disability," 42 U.S.C. § 12132 (1994); (2) that the dimensions of such prohibition shall be spelled out in regulations to be promulgated by the Attorney General, 42 U.S.C. § 12134(a) (1994); and (3) that such regulations shall be consistent with the Act and with prior regulations found at 28 C.F.R. part 41, 42 U.S.C. § 12134(b) (1994). Regarding the issue of unnecessarily isolated and segregated services, the latter regulations, issued in 1978 and applicable to recipients of federal financial assistance, establish an unambiguous mandate to "administer programs and activities in the most integrated setting appropriate to the needs of qualified [persons with disabilities]." 28 C.F.R. § 41.51(d) (1998).

Congress could hardly have been clearer in requiring that services for individuals with disabilities must be provided in the most integrated setting appropriate.

<sup>17</sup> Congress was well aware of the cost data and fiscal conclusions of *amicus* in *Toward Independence* and *On the Threshold of Independence* as it considered the ADA. See, e.g., S. Rep. No. 101-116 at 16-18 (1989) [hereinafter Senate Report]; H.R. Rep. No. 101-485 pt. 2, at 43-47 (1990) (Committee on Education and Labor), reprinted in 1990 U.S.C.C.A.N. 303, 325-26 [hereinafter Education & Labor Committee Report]. In introducing the 1989 version of the ADA in the 101st Congress, Senator Harkin devoted a substantial portion of his introductory statement to discussing cost ramifications. 135 Cong. Rec. 8505, 8507-08 (1989) (statement of Sen. Harkin). Among other observations he stressed "the economic benefits to society in terms of reductions in the deficit from getting people . . . out of institutions . . . ." *Id.* at 8507-08 (emphasis added). See also 134 Cong. Rec. 9375, 9378 (1988) (statement of Sen. Weicker) ("the costs associated with this bill are a small price to pay for opening up our society to persons with disabilities").

Petitioner contends that this requirement does not apply to a certain category of services -- those designed and rendered specifically for individuals with disabilities and not for individuals without disabilities. *Amicus* notes that many state and local governments provide a variety of social service, housing, health care, and other programs some of whose services are arguably equivalent to services provided at treatment and habilitation facilities serving individuals with disabilities. Such a line of argument is superfluous, however, because the simple fact is that the Act does not admit of the exception the petitioners suggest.

By its terms, Title II's prohibitions of discrimination apply to "the services, programs, or activities of a public entity." 42 U.S.C. § 12132 (1994). The Act defines the term "public entity" comprehensively to include "any State or local government," and "any department, agency, special purpose district, or other instrumentality of a State or States or local government." 42 U.S.C. §§ 12131(1)(A) & (B) (1994). A department, agency, or facility that provides treatment or habilitation services for people with disabilities clearly falls within the definition of "public entity."

The statutory phrasing does not admit exceptions. Title II's definition of "public entity" and the phrase "services, programs, or activities of a public entity" were construed in *Pennsylvania Dept. of Corrections v. Yeskey*, 118 S.Ct. 1952 (1998). This Court declared that "the ADA plainly covers state institutions without any exception that could cast the coverage of prisons into doubt." *Id.* at 1954. The petitioners in *Yeskey* argued that the ADA does not mention prisons and prisoners. The Court noted the ADA reference, clearly relevant in the present case, to discrimination in such critical areas as . . . institutionalization," 42 U.S.C. § 12101(a)(3) (1994), and concluded that, even if the term "institutionalization" were considered not to include penal institutions, the broad statutory definition of "public entity" would still encompass prisons, and the "services, programs, or activities" they provide. *Id.* at 1955-56. The Court ruled that,

even assuming that Congress did not envision that the ADA would be applied to state prisoners, "in the context of an unambiguous statutory text that is irrelevant." *Id.* at 1956. The Court declared that "the fact that a statute can be 'applied in situations not expressly anticipated by Congress does not demonstrate ambiguity. It demonstrates breadth.'" *Id.* at 1956, quoting *Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 499 (1985). The Court concluded that "the plain text of the ADA unambiguously extends to state prison inmates. . . ." *Id.* at 1956.

In accordance with the *Yeskey* decision, and the ADA statutory purpose of establishing a "comprehensive national mandate for the elimination of discrimination," 42 U.S.C. § 12101(b)(1) (1994), state residential treatment and habilitation facilities, *i.e.*, "institutions," and the "services, programs, or activities" they render are manifestly included within the scope of the integration and other nondiscrimination requirements of Title II pursuant to "the plain text of the ADA." *Id.*

Indeed, Petitioners' suggestion of an exception for treatment and habilitation services for people with disabilities would undercut fundamental objectives reflected in statutory language, including the goals of "full participation," of addressing societal practices that "isolate and segregate individuals with disabilities," of eliminating persisting "discrimination against individuals with disabilities in such critical areas as . . . institutionalization," and of establishing a "comprehensive national mandate for the elimination of discrimination." 42 U.S.C. §§ 12101(a)(8), (2), (3), & (b)(1) (1994). Petitioners' purported exception would exclude from the Act's coverage a class of services that can result in one of the most serious forms of isolation and unnecessary segregation of individuals with disabilities. Nothing in the Act supports such an anomaly.

#### B. The Legislative History

In reviewing federal laws, the standard is, of course, not what Congress should have said in legislation but rather what



it did say; the courts are not to second guess the policy choices underlying clear legislative language.<sup>18</sup> The previous sections have all pointed to a single conclusion -- that the ADA mandates, clearly and unambiguously, that state and local government treatment and habilitation service programs for individuals with disabilities must provide such services in the most integrated setting appropriate to the needs of the individual with a disability. The legislative history of the ADA only serves to reinforce the conclusion that Congress intended the Act to prohibit unnecessary isolation and segregation in treatment and habilitation services for individuals with disabilities provided by instrumentalities of state and local governments.

The legislative history makes clear that prohibiting unnecessary isolation and segregation of individuals with disabilities is a key objective of the Act as a whole and of Title II in particular. The Committee reports are quite explicit in this regard.<sup>19</sup> Numerous statements during congressional

<sup>18</sup> See, e.g., *Griffin v. Oceanic Contractors, Inc.*, 458 U.S. 564, 570 (1982) ("Our task is to give effect to the will of Congress, and where its will has been expressed in reasonably plain terms, 'that language must ordinarily be regarded as conclusive'"), quoting *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980). An exception is where the plain language of a statute produces absurd results and the statute "can't mean what it says." *Green v. Bock Laundry Machine Co.*, 490 U.S. 504, 511 (1989), quoting *Campbell v. Greer*, 831 F.2d 700, 703 (7th Cir. 1987).

<sup>19</sup> See, e.g., S. REP. NO. 101-116 at 6 (1989) ("One of the most debilitating forms of discrimination is segregation") [hereinafter SENATE REPORT]; *id.* at 20 (the ADA is "a clear and comprehensive national mandate for the elimination of discrimination and for the integration of persons with disabilities into the economic and social mainstream of American life"); H.R. REP. NO. 101-485 pt. 3, at 26 (1990) (Committee on the Judiciary), reprinted in 1990 U.S.C.C.A.N. 445, 449 (the ADA "promises a new future: a future of inclusion and integration, and the end of exclusion and segregation") [hereinafter HOUSE JUDICIARY COMMITTEE REPORT]; *id.* at 49-50 (1990), reprinted in 1990 U.S.C.C.A.N. at 472-73 ("[t]he purpose of title II is to continue to break down barriers to the integrated participation of people with disabilities in all aspects of

debates likewise stressed the fundamental importance of prohibiting segregation.<sup>20</sup> Two of the ADA Committee reports included distinct sections discussing the effects of segregation and other forms of discrimination upon individuals with disabilities,<sup>21</sup> and upon society as a whole.<sup>22</sup>

The legislative history underscores the conclusion compelled by the statutory language that Congress did not intend to exempt any category of programs, activities and services from the integration requirement of Title II. The

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community life"; "integrated services are essential to accomplishing the purposes of title II").

<sup>20</sup> See, e.g., 135 CONG. REC. 8505, 8506 (1989) (statement of Sen. Harkin, sponsor of 1989 version of ADA) (ADA "sends a clear message to ... State and local governments ... that the full force of the Federal law will come down on anyone who continues to subject persons with disabilities to discrimination by segregating them...."). Similarly, see 134 CONG. REC. 9375 (1988) (statement of Sen. Weicker); 135 CONG. REC. 19800, 19803 (1989) (statement of Sen. Harkin); 136 CONG. REC. 10872 (1990) (statement of Rep. Weiss); 135 CONG. REC. 19878 (1989) (statement of Sen. Chafee) (ADA "will integrate fully those with disabilities into everyday American life").

<sup>21</sup> SENATE REPORT at 15-18; EDUCATION & LABOR COMMITTEE REPORT at 41-47, reprinted in 1990 U.S.C.C.A.N. at 323-29. The Committees cited testimony of various witnesses who described such effects on persons with disabilities in the following terms: "has stripped us as disabled people of pride and dignity," of which "[t]he stigma scars for life," SENATE REPORT at 16; EDUCATION & LABOR COMMITTEE REPORT at 42, reprinted in 1990 U.S.C.C.A.N. at 324; caused feelings of "isolation, the sense of helplessness and the sense of no ability to relate to other people" resulting from "being held separate" and other forms of discrimination, EDUCATION & LABOR COMMITTEE REPORT at 41, reprinted in 1990 U.S.C.C.A.N. at 323; "robbed of our dignity, of our self-respect . . ." and suffer "the elimination of dignity associated with being a human being . . ." *Id.* The Committees concluded that such "[d]iscrimination results in social isolation and in some cases suicide." *Id.* at 42, reprinted in 1990 U.S.C.C.A.N. at 324; SENATE REPORT at 16.

<sup>22</sup> The Committee reports identified such consequences as the waste of human resources and the huge financial costs of maintaining individuals in "dependency." SENATE REPORT at 16-18; EDUCATION & LABOR COMMITTEE REPORT at 43-47, reprinted in 1990 U.S.C.C.A.N. at 325-29.

Senate Committee report and the report of the House Committee on Education and Labor declared in identical language that the "first purpose" of Title II is "to make applicable the prohibition against discrimination on the basis of disability . . . to all programs, activities, and services provided or made available by state and local governments or instrumentalities or agencies thereto . . . ." SENATE REPORT at 44 (emphasis added); EDUCATION & LABOR COMMITTEE REPORT at 84, *reprinted in* 1990 U.S.C.C.A.N. at 366 (emphasis added). Similarly the House Judiciary Committee declared that Title II is intended "to cover all programs of state or local governments, regardless of the receipt of federal financial assistance." HOUSE JUDICIARY COMMITTEE REPORT at 49, *reprinted in* 1990 U.S.C.C.A.N. at 472 (emphasis added). Nor did the Committee state any exception to its statement that "integrated services are essential to accomplishing the purposes of title II." *Id.* at 50, *reprinted in* 1990 U.S.C.C.A.N. at 473. In the statement accompanying his introduction of the ADA bill in the Senate, Senator Harkin noted that the Act was needed to address the absence of protection against discrimination in "all services provided by State and local governments. . . ." 135 CONG. REC. 8505, 8508 (1989) (statement of Sen. Harkin). Similarly, *see, e.g.*, 136 CONG. REC. 10868 (1990) (statement of Rep. Edwards) (ADA extends protections "to all programs, activities and services of State or local governments").

The legislative history of the ADA not only demonstrates that Congress intended to provide comprehensive protection from unnecessary isolation and segregation of people with disabilities under Title II, but also provides strong evidence that Congress intended treatment and habilitation programs to be subject to the integration mandate. One of the congressional hearings on the ADA legislation in the 100th Congress devoted considerable attention to institutionalization. *Americans with Disabilities Act of 1988: Hearing on H.R. 4498 Before the Subcommittee on Select Education of the House Committee on Education and Labor*, 100th Cong. (1988). Witnesses provided dramatic, and at times graphic, descriptions of the damaging

effects of segregated treatment facilities.<sup>23</sup> Senator Harkin made the intent to address segregated treatment programs crystal clear, when, in introducing the 1989 version of the ADA in the 101st Congress, he expressly listed, as one of the intended consequences of the legislation, "getting people . . . out of institutions . . . ." 135 CONG. REC. 8505, 8508 (1989) (statement of Sen. Harkin).

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<sup>23</sup> *See, e.g., id.* at 62 (statement of Bill Knight, Chairman, Greater Waterbury Consumer Action Forum) ("services are woefully inadequate and a segregated society is created due to institutionalization"); *id.* at 65 (statement of Ed Preneta, Director, Connecticut Developmental Disabilities Office) ("people with mental retardation locked up in institutions;" ADA is "an opportunity to reach the most segregated members of our society"); *id.* at 23 (statement of Elmer Bartels, Commissioner, Massachusetts Rehabilitation Commission) (advocating "a reasonable level of services that cost less where people can live independently in the community than it costs to keep people in dependent settings within nursing homes, public health hospitals and institutions," and questioning "cost-effectiveness" of placing people with disabilities in treatment facilities equivalent to "consigning them . . . to 'terminal' care in an institution"); *id.* at 101 (statement of Stanley Koslowski, Connecticut Office of Protection and Advocacy) (describing the "stigma" associated with "institutionalization" for psychiatric disabilities as "probably more severe than any other stigma"); *id.* at 1066 (statement of William Cavanaugh, consumer of Massachusetts mental health services) (complaining of "abusive treatment and human rights violations" in mental institutions). One witness with a disability spoke of what she described as her "realistic," "constant fear" that she might be "institutionalized," and described in graphic terms her experience of residential treatment facilities:

. . . I have seen these institutions. The smell of human waste and detergent has stuck in my throat. I have looked into the vegetative eyes of its inmates in their sterile environments. I have heard of the premature death ratio and prevalence of pneumonia and necrotic decubitus, literally allowing them to rot in their beds, these living dead, our imprisoned Americans with disabilities. *Id.* at 163 (statement of Cindy Miller).

She added her plea that Congress should "[p]lease enact the ADA quickly." *Id.* at 172.



Subsequently during Senate hearings in 1989, former Senator Weicker testified that our country had "created monoliths of isolated care in institutions and in segregated educational settings" and that "that isolation and segregation" is "the basis of the discrimination faced by many disabled people today." *Americans with Disabilities Act of 1989: Hearing on S. 933 Before the Senate Committee on Labor and Human Resources and the Subcommittee on the Handicapped*, 101st Cong. 215 (1989) (statement of Hon. Lowell Weicker).

In congressional debates on the ADA, Representative Miller declared of people with disabilities that "[s]ociety has made them invisible by shutting them away in segregated facilities . . . ." 136 CONG. REC. 10877 (1990) (statement of Rep. Miller). Senator Kennedy referred to "American apartheid" and the "unthinking and unacceptable practices by which disabled Americans today are segregated, excluded, and fenced off from fair participation in our society . . . ." 135 CONG. REC. 8514 (1989) (statement of Sen. Kennedy). During the final passage of the ADA in the House, Representative Dellums declared:

The history of different, separate, and unequal treatment of persons with disabilities could hardly be clearer. . . . The Americans with Disabilities Act is a plenary civil rights statute designed to halt all practices that segregate persons with disabilities and those that treat them inferior or differently. By enacting the ADA, we are making a conscious decision to reverse a sad legacy of segregation and degradation.

136 CONG. REC. 11467 (1990) (statement of Rep. Dellums).

The inclusion of "institutionalization" in the list of areas of discrimination that the ADA would address was a considered and informed decision of the Congress. The legislative history further buttresses the conclusion mandated by the language of Title II and its implementing regulations,

and the *Yeskey* decision, that Title II's integration mandate applies to state treatment and habilitation services for persons with disabilities as covered services, programs, or activities of a public entity.

### C. ADA Regulations

Title II regulations promulgated by the Attorney General in July 1991 are clear, unambiguous, and comprehensive: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (1998).

These regulations were issued by the Attorney General pursuant to the explicit statutory directive in Title II of the ADA. 42 U.S.C. § 12134(a) (1994) ("Not later than 1 year after July 26, 1990, the Attorney General shall promulgate regulations in an accessible format that implement this subtitle"). They also comport with the statutory directive that such regulations shall be consistent with the Act and with regulations found at 28 C.F.R. part 41, implementing § 504 of the Rehabilitation Act. 42 U.S.C. § 12134(b) (1994). Regarding the issue of unnecessarily isolated and segregated services, the ADA Title II regulations track very closely the referenced regulations that required covered entities to "administer programs and activities in the most integrated setting appropriate to the needs of qualified [persons with disabilities]." 28 C.F.R. § 41.51(d) (1998). It is clear that 28 C.F.R. § 35.130(d) represents a conscientious response by the Attorney General to express congressional directives.

Because the Title II regulations were responsive to a direct statutory mandate that assigned the task of fleshing out the specific forms of discrimination contained in the broad statutory prohibition of discrimination in public services, these regulations qualify for "*Chevron* deference" and are to be "given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Chevron, U.S.A., Inc. v. Nuclear Regulatory Defense Council, Inc.*, 467

U.S. 837, 844, 104 S.Ct. 2778, 2782, 81 L.Ed.2d 694 (1984). See, *Bragdon v. Abbott*, 118 S.Ct. 2196, 2209 (1998) (Attorney General's regulations under Title III of the ADA entitled to *Chevron* deference).

The application and enforcement of 28 C.F.R. § 35.130(d) (1998) to prohibit unnecessary isolation and segregation in treatment and habilitation services for individuals with disabilities provided by instrumentalities of state and local governments is entirely consistent with the uniform and unwavering understanding of *amicus* in initiating the ADA proposal, of members of Congress in revising and passing the ADA, of the President in signing it into law, and of the Attorney General in issuing Title II regulations, that requiring integrated services and programs is a key component of prohibiting discrimination on the basis of disability.

### III. Conclusion

In developing the ADA proposal and in producing the original version of the ADA first introduced in Congress, *amicus* intended that such a law would prohibit, *inter alia*, a most virulent and damaging form of discrimination -- unnecessarily isolated and segregated treatment and habilitation services for persons with disabilities. Congress repeatedly sought the input of *amicus* on the pending legislation, and several officers and staff of *amicus* were invited to and did testify at congressional hearings. If, as the legislation worked its way through Congress, there had been even a hint that Title II would not prohibit unnecessarily institutionalization, isolation, and segregation in treatment and habilitation services provided by state and local government entities, *amicus* would have protested vehemently. But there was no such hint. *Amicus* was quite comfortable lending its unequivocal support to the final version of the legislation.

Since the enactment of the ADA, *amicus* has continued to monitor progress in regard to integration of treatment and

habilitation services for persons with disabilities. In a 1996 report to the President and Congress, *amicus* observed:

Historically, many people with disabilities, particularly those with mental retardation or mental illness, could access long-term services only if they lived in institutional settings. Many people lived, and continue to live, away from their families and communities in institutions and nursing homes because the community-based long-term services they needed were not available to them. NATIONAL COUNCIL ON DISABILITY, *ACHIEVING INDEPENDENCE: THE CHALLENGE FOR THE 21ST CENTURY* 96-97 (1996) (hereinafter *ACHIEVING INDEPENDENCE*).

This despite the fact that numerous benefits -- to persons with disabilities, to persons without disabilities, and to society in general -- result from integrated services for people with disabilities.<sup>24</sup>

*ACHIEVING INDEPENDENCE* provides data regarding numbers of people with disabilities in treatment and habilitation facilities, and the costs associated with such

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<sup>24</sup> See, e.g., Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 407B414, 439-457 (1991) and the authorities cited therein. Among the benefits of integrated programs the author identifies, are the following:

1. Integration Substantially Improves the Perspective of Nondisabled People Regarding Disability;
2. Integration Significantly Improves the Socialization of Persons with Disabilities with Non-Disabled Peers;
3. Integrated Educational and Training Programs Enhance the Skills Learned by Persons with Disabilities and Better Prepares Persons with Disabilities for Employment; and
4. Integration Improves the Health, Independence, and Affect of Persons with Disabilities, and Renders Persons with Disabilities More Likely to Live, Work, and Recreate in Regular Community Settings. *Id.* at 445-456.



services, *id.* at 99-100; after analyzing such information, *amicus* concluded:

Thousands of individuals continue to live in large institutions and nursing homes when they could live in smaller community settings. Too many people with mental illness remain unserved or underserved in the community. States vary dramatically in their use of institutional services and in the amount of money they spend on alternative services.

*Id.* at 100.<sup>25</sup>

Vigorous implementation of the integration mandate of Title II of the ADA to prohibit unnecessary isolation and segregation in regard to treatment and habilitation services for individuals with disabilities provided by state and local government instrumentalities will bring to fruition the declaration of the House Judiciary Committee that the ADA "promises a new future: a future of inclusion and integration, and the end of exclusion and segregation." HOUSE JUDICIARY COMMITTEE REPORT at 26, *reprinted in* 1990 U.S.C.C.A.N. at 449.

### CONCLUSION

For the foregoing reasons, *amicus* respectfully urges the Court to affirm the decision of the United States Court of Appeals for the Eleventh Circuit.

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<sup>25</sup> For current figures regarding institutional populations and comparisons of costs of institutions and community-based programs, see National Conference of State Legislatures, *Saving Medicaid Money: From Institutions to Community Care*, 25 STATE LEGISLATURES 7 (February 1999).

Respectfully submitted,

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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1998

TOMMY OLMSTEAD, Commissioner, *et al.*,  
v. *Petitioners,*

L.C. and E.W., each by JONATHAN ZIMRING  
as guardian ad litem and next friend,  
*Respondents.*

On Writ of Certiorari to the  
United States Court of Appeals  
for the Eleventh Circuit

**BRIEF AMICI CURIAE  
FOR THE AMERICAN PSYCHIATRIC ASSOCIATION  
AND THE NATIONAL ALLIANCE  
FOR THE MENTALLY ILL  
SUPPORTING RESPONDENTS**

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## TABLE OF CONTENTS

|   | Page |
|---|------|
| TABLE OF AUTHORITIES .....  | ii   |
| INTEREST OF AMICI .....   | 1    |
| STATEMENT .....   | 2    |
| A. Statutory Framework .....  | 2    |
| B. This Litigation .....  | 7    |
| SUMMARY OF ARGUMENT .....   | 9    |
| ARGUMENT .....  | 12   |
| I. The Americans With Disabilities Act Is Reasonably Applied To Preclude Discrimination By The State As A Whole, Not Just Individual "Programs" Or "Services," In The Conditions Attached To Receipt Of Government Services.... | 12   |
| II. Depriving An Individual Of The Important Benefits Of Community Integration, Unless Such A Setting Is Inappropriate For The Individual According To Reasonable Professional Judgment, Is Discrimination Under The ADA....    | 18   |
| III. The Fundamental Alteration Defense, Whose Concrete Meaning Is Not Ripe For Review, Confirms The Reasonableness Of The General Integration Requirement .....  | 25   |
| CONCLUSION .....  | 29   |

## TABLE OF AUTHORITIES

| Cases   | Page       |
|---|------------|
| <i>Allied-Bruce Terminix Cos. v. Dobson</i> , 513 U.S. 265 (1995) .....                     | 15         |
| <i>Adarand v. Constructors, Inc. v. Pena</i> , 515 U.S. 200 (1995) .....                    | 24         |
| <i>Alexander v. Choate</i> , 469 U.S. 287 (1985) .....                                      | 26         |
| <i>AT&amp;T Corp. v. Iowa Utilities Bd.</i> , 119 S. Ct. 721 (1999) .....                   | 15, 27     |
| <i>Auer v. Robbins</i> , 117 S. Ct. 905 (1997) .....  | 12         |
| <i>Bragdon v. Abbott</i> , 118 S. Ct. 2196 (1998) .....                                     | 12, 17, 24 |
| <i>Cedar Rapids Community School Dist. v. Garrett F.</i> , No. 96-1793 (Mar. 3, 1999) ..... | 15, 27     |
| <i>City of Cleburne v. Cleburne Living Center</i> , 473 U.S. 432 (1985) .....               | 22         |
| <i>City of New York v. FCC</i> , 486 U.S. 57 (1988) .....                                   | 27         |
| <i>Fogerty v. Fantasy, Inc.</i> , 510 U.S. 517 (1994) .....                                 | 17         |
| <i>Martin v. OSHRC</i> , 499 U.S. 144 (1991) .....  | 12         |
| <i>Pennhurst State School &amp; Hosp. v. Halderman</i> , 451 U.S. 1 (1981) .....            | 27         |
| <i>Shalala v. Guernsey Memorial Hosp.</i> , 514 U.S. 87 (1995) .....                        | 12         |
| <i>Southeastern Community College v. Davis</i> , 442 U.S. 397 (1979) .....                  | 26         |
| <i>Traynor v. Turnage</i> , 485 U.S. 535 (1988) .....                                       | 17, 18     |
| <i>Youngberg v. Romeo</i> , 457 U.S. 307 (1982) .....                                       | 24         |
| <b>Statutes and Rules</b>   |            |
| 28 C.F.R. § 35.130 .....  | 5          |
| 29 U.S.C. § 790 .....   | 7          |
| § 794a .....  | 5, 16      |
| 42 U.S.C. § 12101 .....   | 2, 3, 19   |
| §§ 12111-12117 .....  | 3          |
| § 12111 .....   | 4, 26      |
| § 12112 .....   | 4, 20, 26  |
| § 12113 .....   | 4          |
| § 12116 .....   | 4          |
| §§ 12131-12165 .....  | 4          |
| § 12131 .....   | passim     |
| § 12132 .....   | passim     |
| § 12133 .....   | 4, 5       |

## TABLE OF AUTHORITIES—Continued

|  | Page         |
|--|--------------|
| § 12134 .....  | 4, 5, 15, 19 |
| §§ 12141-12165 .....   | 4            |
| §§ 12181-12189 .....   | 6            |
| § 12181 .....  | 6            |
| § 12182 .....  | 6, 7, 20, 26 |
| § 12201 .....  | 7            |
| <b>Congressional Materials</b>   |              |
| H.R. Rep. 485, Part II, 101st Cong., 2d Sess. (1990) .....   | 3, 20        |
| H.R. Rep. 485, Part III, 101st Cong., 2d Sess. (1990) .....  | 3, 20, 27    |
| S. Rep. 116, 101st Cong., 1st Sess. (1989) .....   | 3            |
| <b>Miscellaneous</b>   |              |
| P. Appelbaum, <i>Almost A Revolution: Mental Health Law and the Limits of Change</i> (1994) ....   | 21           |
| Braun <i>et al.</i> , "Overview: Deinstitutionalization of Psychiatric Patients, a Critical Review of Outcome Studies," 138 <i>Am. J. Psychiatry</i> 736 (1981) .....                                | 23           |
| Dauwalder, "Cost-Effectiveness Over 10 Years," 30 <i>Soc. Psychiatry &amp; Psychiatric Epidemiol.</i> 171 (1995) .....   | 28           |
| Fenton <i>et al.</i> , "Randomized Trial of General Hospital and Residential Alternative Care for Patients with Severe and Persistent Mental Illness," 155 <i>Am. J. Psychiatry</i> 516 (1998) ..... | 23           |
| R.J. Isaac & V.C. Armat, <i>Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill</i> (1990) .....   | 22, 23       |
| Lehman, "The Quality of Life of Chronic Patients in a State Hospital and in Community Residences," 37 <i>Hospital &amp; Community Psychiatry</i> 901 (1986) .....                                    | 23           |
| Mechanic, "The Challenge of Chronic Mental Illness: A Retrospective and Prospective View," 37 <i>Hospital and Community Psychiatry</i> 891 (1986) .....  | 28           |



## TABLE OF AUTHORITIES—Continued

|   | Page |
|---|------|
| Miller & Rago, "Fiscal Incentives to Development of Services in the Community," 39 <i>Hospital &amp; Community Psychiatry</i> 595 (1988) .....  | 28   |
| R. Munich & W. Sledge, "Treatment Settings: Providing a Continuum of Care for Patients with Schizophrenia or Related Disorders," in G. Gabbard, ed., 1 <i>Treatments of Psychiatric Disorders</i> 1075-90 (2d ed. 1995) ..... | 23   |
| Rothbard <i>et al.</i> , "Unbundling of State Hospital Services in the Community: The Philadelphia State Hospital Story," 24 <i>Administration and Policy in Mental Health</i> 391 (1997) .....                               | 23   |
| Sledge <i>et al.</i> , "Day Hospital/Crisis Respite Care Versus Inpatient Care, Part II: Service Utilization and Costs," 153 <i>Am. J. Psychiatry</i> 1074 (1996) .....   | 28   |
| Stein, "A System Approach to Reducing Relapse in Schizophrenia," 54 <i>J. Clin Psychiatry</i> 7 (1993) .....  | 28   |
| L. Stein & M.A. Test, "A State Hospital Initiated Community Program," in J. Talbott, ed., <i>The Chronic Mentally Ill: Treatment, Programs, Systems</i> 173 (1981) .....  | 23   |
| M.A. Test, "Training in Community Living," in R.P. Lieberman, <i>Handbook of Psychiatric Rehabilitation</i> 153-70 (1992) .....   | 23   |
| E.F. Torrey, <i>Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill</i> (1988) .....   | 22   |
| E.F. Torrey, <i>Out of the Shadows: Confronting America's Mental Illness Crisis</i> (1997) .....  | 21   |
| Wasylenki, "The Cost of Schizophrenia," 39 <i>Canadian J. Psychiatry</i> 565 (1994) .....   | 28   |
| Williams & Dickson, "Economics of Schizophrenia," 40 <i>Canadian J. Psychiatry</i> 560 (1995) .....   | 28   |

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BRIEF *AMICI CURIAE*  
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INTEREST OF AMICI

The American Psychiatric Association (APA), with more than 40,000 members, is the Nation's largest organization of physicians specializing in psychiatry.<sup>1</sup> It has participated in numerous cases in this Court. *See, e.g., Kansas*

<sup>1</sup> Letters from the parties consenting to the filing of this brief have been filed with the Clerk. *See* Sup. Ct. R. 37.3. No person except *amici* and their counsel contributed to the writing of this brief or made a monetary contribution toward its preparation or submission. *See* Sup. Ct. R. 37.6.

*v. Hendricks*, 521 U.S. 346 (1997); *Jaffee v. Redmond*, 518 U.S. 1 (1996); *City of Edmonds v. Oxford House, Inc.*, 514 U.S. 725 (1995); *Youngberg v. Romeo*, 457 U.S. 307 (1982). The APA seeks in this case, as in others, to ensure that state decisions about the care and treatment of persons with mental illness or other disabilities properly serve the individuals' best interests—here, by not unjustifiably depriving individuals of the benefits of integration into community settings when such settings are appropriate for them.

The National Alliance for the Mentally Ill (NAMI), with more than 200,000 members and 1,200 state and local affiliates, is the Nation's leading grassroots advocacy organization dedicated exclusively to improving the lives of persons with severe mental illnesses, including schizophrenia, bipolar disorder (manic-depressive illness), major depression, obsessive-compulsive disorder, and severe anxiety disorders. NAMI seeks in this case to ensure that people with severe mental illnesses are not unnecessarily denied opportunities to enjoy the benefits of living safely and successfully in the community, when they are able to do so, and receive the treatment required to enable them to live in the most integrated settings appropriate to their needs.

## STATEMENT

### A. Statutory Framework

The issue in this case is best understood in light of the provisions and structure of the Americans with Disabilities Act of 1990 (the ADA), 42 U.S.C. § 12101 *et seq.*, as a whole. Congress began the ADA with express findings and then set forth prohibitions against discrimination in employment (Title I), public services (Title II), and public accommodations (Title III). The statute as a whole is intended "to provide a clear and comprehensive national mandate for the elimination of discrimination

against individuals with disabilities" (§ 12101(b)) and to work significant changes across a wide range of private and public practices. *See generally* H.R. Rep. 485, Part III, 101st Cong., 2d Sess. 28-34 (1990); H.R. Rep. 485, Part III, 101st Cong., 2d Sess. 23-26 (1990) (26: "The ADA is a comprehensive piece of civil rights legislation which promises a new future: a future of inclusion and integration, and the end of exclusion and segregation."); S. Rep. 116, 101st Cong., 1st Sess. (1989).

*Findings.* Several of Congress's findings speak directly to isolation of individuals with disabilities from the ordinary community settings that people generally take for granted. Congress's very first finding after noting the number of Americans with disabilities was that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities, continue to be a serious and pervasive social problem." § 12101(a)(2). Other findings repeat and expand on this recognition that unnecessary isolation and segregation are a "form[] of discrimination." Congress included "segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities" in a list of "various forms of discrimination." § 12101(a)(5). Congress declared that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." § 12101(a)(8). Congress added that "unfair and unnecessary discrimination and prejudice denies . . . the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous." § 12101(a)(9).

*Employment.* Title I of the ADA addresses employment. §§ 12111-12117. It defines "qualified individual



with a disability" based on the ability to perform "the essential functions" of the job. § 12111(8). The definition adds that "consideration shall be given to the employer's judgment as to what functions of a job are essential." § 12111(8).

The basic rule of Title I is a ban on "discrimination" in employment. § 12112(a). The statute then itemizes what discrimination "includes." § 12112(b). Practices that "segregat[e] . . . in a way that adversely affects the opportunities or status of . . . [an] employee because of the disability" are included. § 12112(b)(1). Also included are refusals to make "reasonable accommodations" that would impose no "undue hardship" (§ 12112(b)(5)(A)), a standard that is defined to mean "significant difficulty or expense, when considered in light of" a number of factors, focused on but not limited to cost considerations (§ 12111(10)). In a similar vein, the Act adds a defense for certain employment standards if they are "job-related and consistent with business necessity," subject to a "reasonable accommodation" limitation. § 12113(a). The Equal Employment Opportunity Commission is authorized and directed to "issue regulations . . . to carry out" Title I. § 12116.

*Public Services.* Title II of the ADA applies to "public services" furnished by governmental entities. §§ 12131-12165. In addition to a host of provisions governing transportation services (§§ 12141-12165), Title II sets forth four generally applicable provisions (§§ 12131-12134). These provisions apply to any "public entity," which includes a "State or local government" as a whole, as well as particular departments or agencies. § 12131(1).

The core term, "qualified individual with a disability," is based on "meet[ing] the essential eligibility require-

ments for the receipt of services or the participation in programs or activities provided by a public entity." § 12131(2). The basic anti-discrimination rule, then, is that, "[s]ubject to the provisions of [Title II], no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." § 12132. After applying the remedy provisions of 29 U.S.C. § 794a—the Rehabilitation Act—to this prohibition (§ 12133), Title II directs the Attorney General to "promulgate regulations . . . that implement" the prohibition (§ 12134(a)), specifying that (except for three designated areas) the regulations shall not only be consistent with the ADA as a whole but also with the so-called "coordination regulations" promulgated by the Department of Health, Education, and Welfare on January 13, 1978, under Section 504 of the Rehabilitation Act, 29 U.S.C. § 794. § 12134(b).<sup>2</sup>

Acting pursuant to that directive, the Attorney General has promulgated regulations stating: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d); *see* Pet. Br. App. 13a-14a. The regulations further provide that a public entity must make "reasonable modifications" to its practices to avoid discrimination "unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." 28 C.F.R. § 35.130(b)(7); Pet. Br. App. 13a. The Attorney General explained, upon promulgating these regulations, that they were "intended to pro-

<sup>2</sup> The "coordination regulations" that the Act refers to, as they were promulgated in January 1978, are printed as an appendix to Petitioners' Brief. Pet. Br. App. 1a-5a.

hibit exclusion and segregation of individuals with disabilities," that "[i]ntegration is fundamental to the purposes of the Americans with Disabilities Act" because "[p]rovision of segregated accommodations and services relegates persons with disabilities to second-class status," and that, "in most instances, separate programs for individuals with disabilities will not be permitted." Pet. Br. App. 17a-18a (emphases added by petitioners omitted).

*Public Accommodations.* Title III of the ADA governs public accommodations offered by private entities. §§ 12181-12189. After defining key terms such as "public accommodations" (§ 12181), Title III states a general rule that no one "shall be discriminated against on the basis of disability in the full and equal enjoyment of goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation . . . ." § 12182(a). The next subsection, entitled "construction," then lays out a series of standards giving specific meaning to the bar on discrimination. § 12182(b).

The "construction" subsection first designates a number of actions or inactions that "shall be discriminatory," including "denial of the opportunity . . . to participate in or benefit from" a defendant's goods, services, etc.; affording such an opportunity to an individual with a disability "that is not equal to that afforded to other individuals"; and providing a good, service, etc. "that is different or separate from that provided to other individuals, unless such action is necessary" to ensure a comparably effective benefit. § 12182(b)(1)(A). Reinforcing and extending the foregoing presumption against separateness, the same subsection specifies that goods, services, etc. "shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual" (§ 12182(b)(1)(B)) and that, even if a separate

program is justified, the opportunity to participate in the program that is "not separate or different" may not be denied (§ 12182(b)(1)(C)). The subsection then adds several "specific prohibitions," the broadest of which mirrors Title I's reasonable-accommodation provision by stating that "discrimination includes" several kinds of inaction:

failure "to make reasonable modifications" when "necessary to afford" goods, services, etc. to individuals with disabilities, unless the defendant "can demonstrate that making such modifications would fundamentally alter the nature of such goods, services," etc.;

failure "to take steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services, unless the [defendant] can demonstrate that taking such steps would fundamentally alter the nature of the good, service, [etc.] being offered or would result in an undue burden";

failure "to remove [certain] barriers . . . in existing facilities . . . [or] vehicles . . . where such removal is readily achievable" and, otherwise, "to make such goods, services, [etc.] available through alternative methods if such methods are readily achievable."

§ 12182(b)(2)(A)(ii)-(v).<sup>3</sup>

#### B. This Litigation

L.C. has mild to moderate mental retardation and schizophrenia; E.W. has mild retardation and borderline per-

<sup>3</sup> Title IV of the ADA contains a number of miscellaneous provisions, including Section 12201(a), which states that, except as otherwise provided, the ADA applies no "lesser standard than the standards applied under" the Rehabilitation Act of 1973, 29 U.S.C. § 790 *et seq.*



sonality disorder. *See* Pet. App. 32a-33a; Pet. Br. 8. At different times, both women were admitted to the Georgia Regional Hospital-Atlanta. Pet. Br. 8. In 1995, L.C. brought suit alleging an entitlement under the ADA to be provided her State-provided "habilitation" and treatment services in a community rather than institutional setting, and E.W. intervened. Pet. App. 32a-33a.

While the case was still in the district court, L.C. was given a community placement; and while the case was in the court of appeals, so too was E.W. *See* Pet. Br. 9, 11. Except for the period surrounding needed surgery for kidney problems in E.W.'s case (Pet. Br. 11), it was accepted by the State below, and the State's professional treatment teams determined, that existing community programs constituted, at a minimum, appropriate placements for both L.C. and E.W. *See* Pet. Br. 9-11; Pet. App. 36a ("[t]here is . . . no dispute that plaintiffs can be placed in the community"; "defendants have already placed L.C. in a community-based program"; "the qualified experts are unanimous in their opinion that E.W. *can* be placed in the community, and defendants concede that E.W. qualifies for community-based services" (footnote discussing surgery omitted)); *id.* at 38a-39a ("there is no dispute that defendants already have existing programs providing community services to persons such as plaintiffs"). On that basis, the district court granted summary judgment to L.C. and E.W., holding that they were entitled under the ADA and the Attorney General's implementing regulations to placement in appropriate community settings. *Id.* at 39a.

The court of appeals, in the main, affirmed. Pet. App. 1a-30a. It held: "where, as here, the evidence is clear that all the experts agree that, at a given time, the patient could be treated in a more integrated setting, the ADA

mandates that it do so at that time unless placing that individual would constitute a fundamental alteration in the state's provision of services." *Id.* at 24a; *see id.* at 25a ("the State's own professionals agreed that E.W. could be placed in a less segregated setting"). The court immediately added: "Nothing in the ADA, however, forbids a state from moving a patient back to an institutionalized treatment setting, as the patient's condition necessitates." *Id.* at 24a.

The court of appeals also explained that the demonstrated authority of the State to transfer both its own funds and Medicaid funds between institutional and community settings presumptively made a community setting a "reasonable" accommodation. *Id.* at 26a. Nevertheless, while mere invocation of funding limits cannot justify the continued unnecessary institutionalization, the State has available a defense of "fundamental alteration." *Id.* at 25a-26a. The court remanded the case for the district court to consider the defense, instructing: "Unless the State can prove that requiring it to make these additional expenditures would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides, the ADA requires the State to make these additional expenditures." *Id.* at 29a.<sup>4</sup>

#### SUMMARY OF ARGUMENT

The court of appeals correctly concluded that the ADA is reasonably interpreted and applied, as it has been by the Attorney General pursuant to a broad grant of implementing authority, to mean that an individual with a disability who is being provided government services is

<sup>4</sup> As described below, the district court, on remand from the Eleventh Circuit decision, subsequently rejected the defense in this case.

entitled to be provided those services in a community setting if such a setting is an appropriate one for the individual, subject to a defense that the result would be a "fundamental alteration" of the government services. That principle finds its easiest application in the present case. The State's own professionals determined that community settings were appropriate ones for L.C. and E.W., and existing community-based programs were available to serve them.

Contrary to petitioners' core statutory contention, the fundamental discrimination bar of Title II (§ 12132) is not restricted to *intra*-“program” or *intra*-“service” discrimination, but is reasonably read to bar the State as a whole from demanding that persons with disabilities unjustifiably make an important sacrifice, as a condition of receiving government services, when that sacrifice is not required of other, non-disabled recipients of government services (even different services). The statutory bar applies by its terms to “any public entity,” including (under the express definition, § 12131(2)) the State itself; it forbids disparate access to (collectively) “the services, programs, or activities” of the State, not any particular service, program, or activity; and it also broadly bars the State itself (a public entity) from any “discrimination.” § 12132. The statutory language thus is not limited to discrimination within the confines of a particular “program” or “service.” Moreover, rejection of such an approach not only advances the basic statutory policy, given that the interests at stake here are so vital, but also serves a strong interest in avoiding artificial and dispute-breeding line-drawing about where one “program” stops and another starts. Nothing in the pre-ADA background against which Congress enacted the ADA precludes this reasonable reading of the statute.

Once the focus is reasonably placed on the State as a whole, the substantive discrimination principle is straight-

forward; depriving an individual with a disability of the benefits of community integration, unless such a community setting is inappropriate for the individual, is a form of discrimination (where other recipients of government services need not sacrifice their interests in community integration). The ADA, reflecting a decades-long trend toward reducing institutional populations, makes overwhelmingly clear the congressional determination of the importance of the interests that are damaged, for many individuals with disabilities, by separation from their communities. To be sure, and of great importance, institutional settings are in the best interests of other individuals, and denial of such settings in those situations would work opposite damage. But unless a community setting is inappropriate for a particular individual, as determined according to professional judgment, denial of such setting is discriminatory. In this case, the State's own professionals found community settings appropriate, so there is no occasion to set a standard for review of contrary determinations by a government's professionals.

There is also no occasion, and it would be premature, to explore the exact contours of the “fundamental alteration” defense to an otherwise-valid claim of unlawful discrimination. That defense is consistent with the ADA, and its availability, along with the “qualified individual with a disability” precondition to a claim, necessarily moderates the impact of, and confirms the reasonableness of, the presumptive integration rule at issue here. But the defense was not applied in the ruling before this Court, and its application properly awaits exploration in the lower courts of what real-world effects—possibly cost *savings*—will be produced by the rule. The court of appeals' adoption of the Attorney General's presumptive integration rule should therefore be affirmed.



### ARGUMENT

The Attorney General, construing the regulations adopted pursuant to express implementing authority, has concluded that community integration is required as long as it is appropriate for an individual (as it undisputedly is here), subject to a defense based on "fundamental alteration." The Attorney General is due deference not only in construing her own regulations (see *Shalala v. Guernsey Memorial Hosp.*, 514 U.S. 87, 95 (1995); *Martin v. OSHRC*, 499 U.S. 144, 151 (1991)) but in construing the ADA (*Bragdon v. Abbott*, 118 S. Ct. 2196, 2209 (1998)). Cf. *Auer v. Robbins*, 117 S. Ct. 905, 912 (1997) (deference where there is "no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question"). As long as the mandate is understood not to deprive individuals of institutional services when such services are needed, and the determination of appropriateness reflects professional judgment, which is all that this case presents, the Attorney General's position is a reasonable and therefore valid construction and application of the ADA.

#### **I. The Americans With Disabilities Act Is Reasonably Applied To Preclude Discrimination By The State As A Whole, Not Just Individual "Programs" Or "Services," In The Conditions Attached To Receipt Of Government Services**

Petitioners' principal contention is that Title II of the ADA is limited to *intra-program* or *intra-service* discrimination, so that, as long as a program or service that is limited to persons with disabilities does not unjustifiably exclude or deny its benefits to other qualified persons with disabilities, Title II is automatically satisfied. Pet. Br. 19-21. There are strong reasons for rejecting this contention based on the statutory directive to the Attorney

General to promulgate regulations consistent with the Act as a whole and with the pre-existing "coordination" regulations. Quite apart from any such basis, however, petitioners' view that the Attorney General's construction is impermissible under the ADA should be rejected on the basis of the fundamental statutory prohibition set forth in Section 12132.

A. Reading Section 12132 to bar discrimination only by a particular agency *within* the confines of a particular "program" or "service" is neither required nor perhaps even natural. Instead, the provision is readily read to apply to the State as a whole and to bar discrimination by the government in its overall provision of services. Most strikingly, the proscription expressly applies to "*any* public entity," which is defined to include the "State" itself. It is not just particular agencies, or their programs, that are covered by the prohibition.

An intra-program or intra-service limitation cannot be discerned from other aspects of the statutory language either. Even the initial proscription on exclusion from or denial of the benefits of "the services, programs, or activities of a public entity" is not written in terms of each particular program or service considered separately, but refers generically to a public entity's "services, programs, or activities" in the plural. § 12132. And in any event, the availability of a broader non-program-specific construction is made clear by the catchall phrase that concludes the provision, which directly bars "discrimination by any such entity" without mention of, or limitation to, any "services, programs, or activities." § 12132.

The discriminatory bar, of course, applies only to a "qualified individual with a disability," which requires that the individual "meet[] the essential eligibility requirements

for the receipt of services or the participation in programs or activities provided by a public entity." § 12131(2). That precondition sets limits on who may claim discrimination: only persons—like respondents in this case—who meet the "essential" eligibility requirements of services provided by the State. But this precondition does not serve the distinct function of then defining what constitutes discrimination. In particular, it does not specify that the comparison class, for purposes of determining whether individuals with a disability are unjustifiably being treated worse than individuals without, is always restricted to persons eligible for a specific program. The precondition of a "qualified individual with a disability," accordingly, does not immunize from Section 12132 scrutiny all unjustified differences in treatment between two groups of persons receiving government services (although not the same service).

Petitioners' insistence on a service-by-service or program-by-program application of Section 12132 thus hardly follows from the statutory language, which readily admits a broader perspective consistent with the comprehensive congressional policy and findings. Most simply, if persons with a disability must unjustifiably sacrifice important interests as the price of receiving a government service, while other persons need not make a sacrifice, there is "discrimination" between groups of "similarly situated" persons (Pet. Br. 21) because of disability. For that reason alone, Section 12132 is (presumptively) violated. It also makes sense, given the broad congressional aims, to conclude, under the first part of the section, that such differential treatment is a forbidden denial of the full intended benefits of, and access to, the government's services, when the sacrifice required is unnecessary. Regardless, the proper inquiry under Section 12132 is simply whether the required sacrifice is justified.

This reading is not just textually sound. In selecting the level of specificity at which to apply the statute's anti-discrimination bar, both the fundamental policy of the Act and practical interests in workable application and administration may rightly play a large role. See Pet. Br. 20 (whether an interpretation is "administratively awkward" is a negative consideration in statutory construction); *Allied-Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 275 (1995) (construing statute not only to promote "basic purpose" of law but to avoid "unnecessarily complicating the law and breeding litigation"); *Cedar Rapids Community School Dist. v. Garret F.*, No. 96-1793 (Mar. 3, 1999), slip op. at 9 ("workable interpretation"). Given that the ADA applies sweepingly to government services of almost every stripe, different judgments about the balance of relevant considerations may well be warranted from context to context or issue to issue. Indeed, Congress indicated the need for context-sensitive choices in carrying out the ADA by enacting a classically broad authorization for executive implementation (§ 12134), the usual means for working out the application of broad principles to diverse circumstances in a complex world. See, e.g., *AT&T Corp. v. Iowa Utilities Bd.*, 119 S. Ct. 721, 730 n.6, 733 n.10 (1999).

For the particular issue presented here, both fundamental statutory policy and a strong practicability consideration support a rule broadly forbidding unjustified segregation. As discussed below, ending unjustified separation of persons with disabilities from the life of the community at large, and thus reducing the wounding stigma often associated with such separation, is basic to the aims of the ADA. That policy does not easily accommodate an artificial limitation of the discrimination bar to the confines of particular agency "programs" or "services."



In addition, the Attorney General's general presumptive integration mandate is supported by a reasonable assessment of the serious workability difficulties with petitioners' proposed alternative of a "service"- or "program"-specific perspective. There is nothing self-evident or easy about defining what is the precise "service" or "program" to be used for purposes of determining, as petitioners would require, whether that service or program is being provided in a discriminatory fashion. This case illustrates the difficulty, because Georgia has been providing care for mentally retarded and mentally ill individuals in both community and institutional settings. Does Georgia have one overall service or program or several separate programs? Petitioners' view makes the applicability of Section 12132 turn on the answer to such questions. Given the large measure of arbitrariness involved, it is eminently reasonable to reject the effort to delineate the boundaries of a "service" or "program," at every governmental level in every State, at the threshold of the ADA analysis, at least when the interest at stake is so fundamental to individuals and to the Act. In this circumstance, there is nothing unreasonable about concluding that the line-drawing game is not worth the candle and, instead, applying the anti-discrimination principle to the government entity as a whole.

B. This construction of Section 12132 is in no way precluded by arguments to the effect that Congress, in enacting the ADA, ratified a clear contrary pre-ADA interpretation—either of Section 504 of the Rehabilitation Act, 29 U.S.C. § 794(a), or of the "coordination" regulations on which the Attorney General modeled the ADA regulations. For one thing, Congress was not re-enacting a pre-existing statute, but writing a new one with a new

context and a new agency "delegation." Moreover, Congress used broadened language in the ADA, omitting Section 504's limitation to discrimination "solely" by reason of the disability; set forth detailed findings about and definitions of discrimination; and made a far more sweeping commitment to reform of public treatment of persons with disabilities than it ever had done before. In addition, the demanding premise for any such preclusion—a settled clear meaning or an "unwavering line" of authority (*Bragdon*, 118 S. Ct. at 2208; *Fogerty v. Fantasy, Inc.*, 510 U.S. 517, 531-32 (1994))—is lacking.

In particular, petitioners include a string citation of various lower court decisions under Section 504. See Pet. Br. 26. Their very failure to lay out precisely what those decisions held confirms their limited import. As the court of appeals below explained (Pet. App. 19a-20a), those decisions, while rejecting various claims under Section 504 (including demands for the provision of new government services), do not constitute anything like the clear line of construction-limiting authority that would rule out a reading of the ADA, with its consciously comprehensive findings and policies, as reaching cross-program discrimination (or, more narrowly, a presumptive integration requirement). Moreover, the language of the pre-ADA "coordination" regulations (Pet. Br. App. 1a-5a) readily can support such a construction, and petitioners themselves indicate (Pet. Br. 28-29) that there was no judicial construction of those regulations, limiting them to intra-program or intra-service discrimination, that Congress might have ratified.

Petitioners also mistakenly rely on a statement of this Court in *Traynor v. Turnage*, 485 U.S. 535, 549-50 (1988), to support their limited, intra-program view of

the ADA. See Pet. Br. 23. In the relied-on passage, *Traynor* says only that Section 504 imposes no blanket requirement "that any benefit extended to one category of handicapped persons also be extended to all other categories of handicapped persons." 485 U.S. at 549. This case involves no such asserted requirement of universal extension to all persons with disabilities of all services provided to some persons with disabilities—an assertion that would have to confront the "qualified individual with a disability" precondition that is plainly satisfied here (§ 12131(2)). Rather, unlike *Traynor*, where no handicapped individual was treated worse than any non-handicapped individual, this case involves a core claim of discrimination between persons with disabilities and persons without: the former, to receive critical government services, must sacrifice the important life benefits and opportunities of community integration, while the latter need not. There is no basis for concluding that Congress decisively approved such discrimination, foreclosing an otherwise-reasonable construction of the statutory language under the broad authority it granted to the Attorney General to implement a statute intended to have transformative effects on public and private action alike.

**II. Depriving An Individual Of The Important Benefits Of Community Integration, Unless Such A Setting Is Inappropriate For The Individual According To Reasonable Professional Judgment, Is Discrimination Under The ADA.**

The Attorney General's presumptive integration mandate rests on a simple proposition. A State's deprivation of the benefits of community living, imposed as a condition for a person with a disability to receive a service from the public entity, when not justified by the needs of that individual, is prohibited discrimination (whenever, as will virtually always be the case, other individuals with-

out a disability who are receiving other government services are not subject to the same deprivation as a condition of receiving government services). As long as that principle is applied with the recognition that institutional settings *are* appropriate for some individuals, and with reliance on professional judgment in making the appropriateness determination, it is an unimpeachable implementation of the ADA.

A. The principle at issue is amply supported in the statute. Congress made express findings recognizing that isolation from community settings may be a "form[] of discrimination." § 12101(a)(2). It included "segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities" in a list of "various forms of discrimination." § 12101(a)(5). It declared that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals" (§ 12101(a)(8)) and that "unfair and unnecessary discrimination and prejudice denies . . . the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous" (§ 12101(a)(9)). Living in a community setting is for most people essential to pursuit of a full range of life opportunities and to "full participation, independent living, and economic self-sufficiency." These findings, applicable to the ADA as a whole, properly inform the construction and implementation of the simple, general bar on discrimination in Title II (§ 12132) and support the Attorney General's presumptive integration mandate.

So, too, do the indications of what constitutes discrimination found elsewhere in the ADA, which, indeed, the Attorney General is guided to respect in promulgating regulations (§ 12134(b)). Title I, governing employ-



ment, treats as discrimination practices that "segregat[e] . . . in a way that adversely affects the opportunities or status of . . . [an] employee because of the disability." § 12112(b)(1). Title III, governing public accommodations, presumes discrimination when a service "is different or separate from that provided to other individuals, unless such action is necessary" to ensure comparable "effective[ness]" (§ 12182(b)(1)(A)) and specifies that goods, services, etc. "shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual" (§ 12182(a)(1)(B)). See also § 12182(b)(1)(C) (even if separate program justified, opportunity to participate in the program that is "not separate or different" may not be denied). Those congressional declarations of policy elsewhere in the Act reinforce the reasonableness of the presumptive integration mandate adopted by the Attorney General under Title II.

B. These statutory indications reflect the familiar history of State-operated institutions for the care and treatment of persons with mental illness or retardation. Institutions in their origins were often noble in aim and design. See, e.g., Pet. Br. 3-5. But by the time Congress enacted the ADA in 1990, it had plainly come to favor the provision of mental-health and mental-retardation services in settings as integrated as possible, given the needs of the individuals involved.

The congressional determination reflects at least two important judgments about the price involved in institutional settings for individuals who can handle and benefit from community settings. One is the judgment, familiar in the context of racial segregation, that a powerful stigma often attaches to those who are separated from society—even when the separation is "only" the price of receiving services that, for the individual, are practicably unavoidable. See H.R. Rep. 485, Part II, at 41-43; H.R. Rep.

485, Part III, at 26. The other is the common-sense judgment that isolation from community settings can have far-reaching effects in curtailing the life opportunities of individuals—including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment. For individuals able to manage the process, the ability to choose exposure to the world of opportunities that depend on community integration is invaluable. Indeed, in mental-health terms, the enhancement of such manageable opportunities is near the core of what treatment and "habilitation" are fundamentally designed to achieve.

These judgments are reflected in the strong national consensus and trend over the last two decades to provide services for persons with mental illness or retardation increasingly in community settings and decreasingly in institutional settings. See, e.g., Pet. Br. 6-8; *Amicus Br. for National Conf. Of State Legislatures* 3-4, 10-11.<sup>5</sup> Medically, the advent of new psychiatric medications beginning in the 1950s contributed centrally to making possible this dramatic change. See P. Appelbaum, *Almost A Revolution: Mental Health Law and the Limits of Change* 50 (1994). Financial and governmental commitment to providing the needed community services lagged behind, contributing often to neglect and homelessness. See P. Appelbaum, *supra*, at 51; E.F. Torrey, *Nowhere to Go:*

<sup>5</sup> Since the mid-1950s, the total number of people with mental illnesses in state psychiatric hospitals throughout the United States has been reduced by 85 percent. According to E. Fuller Torrey, a prominent research psychiatrist, there were, in 1955, 558,239 patients with severe mental illness in the nation's public psychiatric hospitals. By 1994, this number had been reduced to 71,619 persons. When adjusted to the growth in total population of the United States during this period, the actual decrease in the numbers of people with severe mental illnesses in public psychiatric hospitals between 1955 and 1994 was 92 percent. E.F. Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* 8-9 (1997).

*The Tragic Odyssey of the Homeless Mentally Ill* (1988); R.J. Isaac & V.C. Armat, *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (1990). But in recent years, various changes in federal as well as state policies have increasingly supported community-based services. See Pet. App. 26a; Pet. Br. 30-31. Today, the widespread recognition of the importance of community integration, both in avoiding stigma that is often attached to separation and in providing the fullest possible range of life opportunities and experiences, is undeniable.

C. To say that the opportunity for community integration is generally an important personal and social good is not, of course, to say that it is the right result for everyone at all times. Some individuals, whether mentally retarded or mentally ill, are not prepared at particular times—perhaps in the short run, perhaps in the long run—for the risks and exposure of the less protective environment of community settings. See *Amicus Br. of Voice of the Retarded* 3-4, 7-8 (“This Court may safely assume that all disabled welcome the maximum liberty which their condition permits. The difference is medical: not all disabilities permit community placement.”); *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 442 (1985) (footnote omitted) (noting wide variation in circumstances of mentally retarded). For such individuals, at such times, an institutional setting may be the best environment for care and treatment, often (though not always) for a temporary period leading to re-integration into community life. To be sure, advances in antipsychotic medications and in treatment programs have meant that most individuals who previously were institutionalized can be treated in community settings—as long, that is, as necessary services are in fact provided in that setting. For

others, however, institutional settings are needed and must remain available.<sup>6</sup>

Accordingly, an extreme position in either direction can be cruel and harmful to the individuals whose interests are at stake. On one hand, isolation from the community, when not justified by the individual's needs, is undoubtedly a serious deprivation for the individual—and also reinforces the very discrimination-promoting attitudes that Congress consciously undertook to combat in the ADA. On the other hand, relegation to the exposure of an insufficiently protective environment, when such protection is needed, may be dangerous and destructive for the individual, as well as for society, in turn undercutting the objectives of the ADA. Sweeping global pronouncements are out of place. It is *individuals'* interests that are stake

<sup>6</sup> See R. Munich & W. Sledge, “Treatment Settings: Providing a Continuum of Care for Patients with Schizophrenia or Related Disorders,” in G. Gabbard, ed., 1 *Treatments of Psychiatric Disorders* 1075-90 (2d ed. 1995); M.A. Test, “Training in Community Living,” in R.P. Lieberman, *Handbook of Psychiatric Rehabilitation* 153-70 (1992); R.J. Isaac & V.C. Armat, *supra*, at 316 (“hospitals play a necessary role in treating mental illnesses”; also reciting research conclusion that hospitals would always have to be available for homicidal, suicidal, or very psychotic patients, citing L. Stein & M.A. Test, “A State Hospital Initiated Community Program,” in J. Talbott, ed., *The Chronic Mentally Ill: Treatment, Programs, Systems* 173 (1981)); Lehman, “The Quality of Life of Chronic Patients in a State Hospital and in Community Residences,” 37 *Hospital & Community Psychiatry* 901 (1986); Braun *et al.*, “Overview: Deinstitutionalization of Psychiatric Patients, a Critical Review of Outcome Studies,” 138 *Am. J. Psychiatry* 736 (1981). We note that institutional settings may not be the only appropriate settings even for individuals needing 24-hour care. See Rothbard *et al.*, “Unbundling of State Hospital Services in the Community: The Philadelphia State Hospital Story,” 24 *Administration and Policy in Mental Health* 391 (1997); Fenton *et al.*, “Randomized Trial of General Hospital and Residential Alternative Care for Patients with Severe and Persistent Mental Illness,” 155 *Am. J. Psychiatry* 516 (1998).



(*cf. Adarand Constructors, Inc. v. Pena*, 515 U.S. 200, 227 (1995) ("basic principle that the Fifth and Fourteenth Amendments to the Constitution protect *persons*, not *groups*")), and individuals' interests and their circumstances vary.

As relevant in the present context, therefore, there is discrimination when an individual with a disability is deprived of a community setting unless such a setting would be contrary to the individual's best interests. That judgment necessarily relies on the professional judgment of those able to assess the individual's needs for care and treatment. There is, however, a natural asymmetry in this standard. If a community setting is *one* appropriate setting, then denial of that setting deprives the individual of vital benefits (without justification in the individual's needs) and must be deemed discriminatory.

D. That standard is met in this case. There is no dispute that community settings are appropriate ones for L.C. and for E.W. That was the judgment of the State's own professionals.

There is, therefore, no need in this case for the Court to confront questions about the degree to which courts, in applying the ADA standard, must scrutinize, evaluate, and if necessary reject an asserted judgment of a public entity's own professionals when disputed by the plaintiff's professionals. Prior to the fundamental policy choice made by Congress in the ADA, this Court both insisted that it was "professional judgment" that mattered and noted some reasons for deference. *Youngberg v. Romeo*, 457 U.S. 307, 322-23 (1982). More recently, under the ADA, this Court in *Bragdon* applied a standard of "objective reasonableness," based on objective scientific considerations, in reviewing a professional's judgment of risk. 118 S. Ct. at 2210-11. The proper judicial approach to the issue of appropriateness under the ADA need not be

resolved in this case, because the State's professionals did deem community placements appropriate, so that there was no occasion for judicial second-guessing of the judgment of the State's professionals.

### III. The Fundamental Alteration Defense, Whose Concrete Meaning Is Not Ripe For Review, Confirms The Reasonableness Of The General Integration Requirement

This Court should reject the suggestion of petitioners (and the limited number of States that have joined them as *amici*) that the presumptive integration mandate should be rejected because it is too intrusive and perhaps counter-productive. At the outset, such a suggestion does not undermine the threshold conclusion of discrimination: discriminatory deprivation of important benefits does not become nondiscriminatory simply because equal treatment would cost the public entity more money. Nor is it an answer to a charge of discrimination in the provision of a service that the service need not be provided at all or might be withdrawn if it had to be provided equally (an argument that could be made of most government services). *See* Pet. Br. 24. In addition, and in any event, the *in terrorem* argument ignores the important limits incorporated into the construction of the ADA at issue here—limits that confirm the reasonableness of the construction.

One important limit, already noted, is set by the threshold requirement that the plaintiff under Title II be a "qualified individual with a disability." § 12132. That term is defined to require the individual to meet "the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." § 12131(2). The ADA thus does not provide for a general right of any individual with a disability, though not qualified for any existing government programs under their essential eligibility requirements, to

demand that the eligibility criteria be modified so as to create programs suitable for a broader class of individuals.

Closely related, the court below, following the Attorney General's position, has provided for a "fundamental alteration" defense to an otherwise-valid claim of discrimination. That defense comports with the ADA. In Title II, the definition of "qualified individual with a disability" speaks of "reasonable modifications" and "essential eligibility requirements." § 12131(2). Title I condemns employers' refusals to make "reasonable accommodations" and allows a defense of "undue hardship" (§ 12112(b)(5)(A)), a standard that is defined to mean "significant difficulty or expense, when considered in light of" a number of factors, focused on but not limited to cost considerations (§ 12111(10)). Title III similarly condemns the failure of providers of public accommodations "to make reasonable modifications" unless the defendant "can demonstrate that making such modifications would fundamentally alter the nature of" the provided services. § 12182(b)(2)(A). And the predecessor of the ADA, namely, Section 504 of the Rehabilitation Act, incorporated a similar limitation. See *Southeastern Community College v. Davis*, 442 U.S. 397, 410, 412-13 (1979) ("fundamental alteration"); *Alexander v. Choate*, 469 U.S. 287, 300 (1985). (Emphases added through this paragraph.) While no question is presented here whether this defense is mandated by the ADA, the defense is unquestionably consistent with the ADA.

The availability of such a defense to the presumptive integration mandate under Title II, along with the "qualified individual" precondition, is one among several reasons why petitioners' federalism-based arguments against that mandate lack merit. See Pet. Br. 32-35. Quite simply, with this defense, the burdens on public entities are sub-

stantially moderated and can hardly be deemed outside what Congress contemplated. Congress clearly understood that "the integration of people with disabilities will sometimes involve substantial short-term burdens, both financial and administrative"—justified by the prospect that "the long-range effects of integration will benefit society as a whole." H.R. Rep. 485, Part III, at 50. Moreover, unlike in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), Congress in the ADA did not merely authorize a "contract" with States under the Spending Power and did not set forth mere aspirational objectives; instead, it clearly imposed an enforceable non-voluntary obligation on the States and other public entities. Cf. *Cedar Rapids*, slip op. 6 (Thomas J., dissenting) ("special rules of construction" apply to Spending Power programs placing "conditions on the receipt of federal funds"). This Court has indicated that, when Congress has thus laid down a broad federal rule that unquestionably displaces state power in an area and granted a federal agency broad authority to implement the command, the proper question is simply whether the exercise of the implementing authority is within the grant, without a special additional federalism hurdle that must be overcome to support its exercise. *City of New York v. FCC*, 486 U.S. 57 (1988); see *AT&T Corp. v. Iowa Utilities Bd.*, 119 S. Ct. at 730 n.6.

A "fundamental alteration" defense, in short, supports the basic rule at issue here. No more need or should be decided about the nature of the defense in this case. The exact nature of the defense has hardly been explored in the lower courts and is not presented at this stage of the present case. Moreover, the nature of the balance contemplated by Congress—between short-term costs and long-term savings, in a statute indisputably ambitious in its



intended effect—is not a matter properly examined in the abstract.

Thus, there are significant factual issues relevant to any elaboration of the standards governing the defense. On one hand, as has been found on remand in the present case,<sup>7</sup> the cost of care or treatment in community settings for particular individuals may often be less than or comparable to costs in institutional settings, either absolutely or for a particular State looking at its own sources of funding (including Medicaid funds).<sup>8</sup> On the other hand, difficult choices may arise if the transfer of individuals leaves high “fixed” costs of needed institutions to be borne in serving a smaller number of individuals, raising their per-person cost “artificially” and creating additional pressure to reduce the availability of institutional settings for those who need them. But discrimination against one

<sup>7</sup> The district court found, in its January 29, 1999, Order: “There is no dispute that the cost of serving plaintiffs in the community is significantly less than serving them in an institution.” Order at 6. The district court added, however, that the State may not actually realize the savings from relocating respondents, “because of fixed overhead costs associated with providing institutional care,” and that (on restricted evidence) it was “unable to determine whether the State has realized any appreciable cost savings by placing [respondents] in the community.” *Id.* at 6.

<sup>8</sup> See Sledge, *et al.*, “Day Hospital/Crisis Respite Care Versus Inpatient Care, Part II: Service Utilization and Costs,” 153 *Am. J. Psychiatry* 1074 (1996); Mechanic, “The Challenge of Chronic Mental Illness: A Retrospective and Prospective View,” 37 *Hospital and Community Psychiatry* 891 (1986) (history of nursing home transfers); Wasylenki, “The Cost of Schizophrenia,” 39 *Canadian J. Psychiatry* 565 (1994); Williams & Dickson, “Economics of Schizophrenia,” 40 *Canadian J. Psychiatry* 560 (1995); Stein, “A System Approach to Reducing Relapse in Schizophrenia,” 54 *J. Clin. Psychiatry* 7 (1993); Dauwalder, “Cost-Effectiveness Over 10 Years,” 30 *Soc. Psychiatry & Psychiatric Epidemiol.* 171 (1995); Miller & Rago, “Fiscal Incentives to Development of Services in the Community,” 39 *Hospital & Community Psychiatry* 595 (1988).

individual is hard to justify on the ground that it benefits another individual, and it is, in any event, far from clear what the real-world tradeoffs will be. Not only must more be known about the number of individuals involved in changes that would not otherwise already be taking place, but account must be taken of the possibilities of consolidating facilities, sharing staffs, instituting mixed uses of facilities, and adopting other measures that might materially reduce the costs of change.

Such prospects may make any specter of harmful tradeoffs more hypothetical than real. The nature of the “fundamental alteration” defense should be explored in concrete settings that will inform the proper answer. Meanwhile, the existence of the defense confirms the reasonableness of the presumptive integration mandate applied in this case.

#### CONCLUSION

The judgment of the court of appeals should be affirmed.

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No. 98-536

**In the Supreme Court of the United States**

OCTOBER TERM, 1998

**TOMMY OLMSTEAD, COMMISSIONER OF THE  
DEPARTMENT OF HUMAN RESOURCES OF THE STATE OF  
GEORGIA, ET AL.,**  
*Petitioner,*

v.

**L.C. AND E.W., EACH BY JONATHAN ZIMRING,  
AS GUARDIAN AD LITEM AND NEXT FRIEND,**  
*Respondents.*

**ON WRIT OF CERTIORARI TO THE UNITED STATES  
COURT OF APPEALS FOR THE ELEVENTH CIRCUIT**

**AMICUS CURIAE BRIEF OF 58 FORMER STATE  
COMMISSIONERS AND DIRECTORS OF  
MENTAL HEALTH AND DEVELOPMENTAL  
DISABILITIES, ET AL. IN SUPPORT OF  
RESPONDENTS**

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## TABLE OF CONTENTS

|   |    |
|---|----|
| INTEREST OF <i>AMICI CURIAE</i> .....   | 1  |
| SUMMARY OF ARGUMENT .....   | 2  |
| ARGUMENT .....  | 4  |
| I. COMMUNITY INTEGRATION DOES NOT<br>IMPOSE UNREASONABLE BURDENS ON THE<br>STATES.....  | 4  |
| A. Community Integration Will Not Result in<br>Improper or Careless Deinstitutionalization. ....  | 4  |
| B. States Already Provide Most Disability Services in<br>the Community.....   | 6  |
| C. Federal Funding is Available to Assist States in<br>Paying for Community Care. ....  | 9  |
| D. Community Care Costs Less than<br>Institutionalization.....  | 13 |
| II. RESISTANCE TO COMMUNITY INTEGRATION<br>IS THE RESULT OF HISTORIC<br>DISCRIMINATION AGAINST PEOPLE WITH<br>DISABILITIES, WHICH IS PRECISELY THE<br>SOCIAL ILL THE ADA AND THE INTEGRATION<br>MANDATE WERE MEANT TO CORRECT. .... | 21 |
| CONCLUSION .....  | 27 |
| APPENDIX .....  | ia |

## TABLE OF AUTHORITIES

|  | Page(s)  |
|--|----------|
| <u>Alabama Nursing Home Ass'n v. Harris</u> ,<br>617 F.2d 388 (5 <sup>th</sup> Cir. 1980).....                                 | 12       |
| <u>Cable v. Dept. of Developmental Services of the<br/>State of Calif.</u> , 973 F. Supp. 937 (C.D. Cal. 1997) .....           | 5        |
| <u>Charles Q. v. Houston</u> , 1997 U.S. Dist. Lexis<br>17305 (M.D. Pa. 1997).....   | 5        |
| <u>City of Cleburne v. Cleburne Living Center</u> ,<br>473 U.S. 432 (1985) .....   | 21, 24   |
| <u>Concerned Parents to Save Dreher Park Center<br/>v. City of West Palm Beach</u> ,<br>846 F. Supp. 986 (S.D. Fla. 1994)..... | 12       |
| <u>Helen L. v. DiDario</u> , 46 F.3d 325 (3 <sup>rd</sup> Cir.),<br>cert. denied, 516 U.S. 813 (1995).....                     | 17, 26   |
| <u>Int'l Union, United Automobile Workers of America<br/>v. Johnson Controls, Inc.</u> , 499 U.S. 187 (1991) .....             | 13       |
| <u>Kathleen S. v. Dept. of Public Welfare</u> ,<br>10 F. Supp.2d 476 (E.D. Pa. 1998).....                                      | 5        |
| <u>Kroll v. St. Charles County, Missouri</u> ,<br>766 F. Supp. 744 (E.D. Mo. 1991) .....                                       | 13       |
| <u>L.C. v. Olmstead</u> , 138 F.3d 893 (11 <sup>th</sup> Cir. 1998) .....  | 5, 6, 12 |
| <u>L.C. v. Olmstead</u> , 1997 WL 148674<br>(N.D. Ga., March 26, 1997) .....   | 17       |

|   |   |
|---|---|
| <u>Williams v. Wasserman</u> , 937 F. Supp. 524<br>(D. Md. 1996)..... | 5 |
|---|---|

### Statutes, Rules and Regulations

|  |    |
|--|----|
| 42 U.S.C. §§ 300x <u>et seq.</u> ..... | 12 |
| 42 U.S.C. § 1396d(a)(12) .....         | 11 |
| 42 U.S.C. § 1396d(a)(13) .....         | 11 |
| 42 U.S.C. § 1396d(a)(14) .....         | 11 |
| 42 U.S.C. § 1396d(a)(15) .....         | 10 |
| 42 U.S.C. § 1396d(a)(19) .....         | 11 |
| 42 U.S.C. § 1396d(a)(B) .....          | 11 |
| 42 U.S.C. § 1396d(d).....              | 10 |
| 42 U.S.C. § 1396n(b).....              | 11 |
| 42 U.S.C. § 1396n(c).....              | 15 |
| 42 U.S.C. § 1396n(c)(1) .....          | 10 |
| 42 U.S.C. § 1396n(g).....              | 11 |
| 42 U.S.C. §§ 8011-8013 .....           | 12 |
| 42 U.S.C. § 12101(a)(2) .....          | 21 |
| 42 U.S.C. § 12101(b)(1).....           | 21 |
| GA. CODE ANN. § 37-3-64.....           | 19 |



|                                       |    |
|---------------------------------------|----|
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## INTEREST OF AMICI CURIAE<sup>1</sup>

This case raises issues of great importance to the mental health and disability communities in this country. As former state commissioners and directors of mental health and developmental disabilities and the state of Oregon, *amici* are uniquely positioned to speak to many of the policy issues presented by this case, including how public systems of care may operate in a manner that best addresses the needs of people with disabilities and that is cost-effective for the primary providers of care, the fifty states. As a result of their considerable experience not only in serving people with disabilities directly but also in managing state systems of care, *amici* have a breadth of understanding about the broader social implications of this case, such as the mechanisms states use to fund disability services and the long and tortured history that lies behind the states' treatment of people with mental disabilities.

*Amici* are from thirty-six different states: Alabama, Alaska, Arizona, California, Connecticut, Colorado, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Wisconsin, Washington, Wyoming, and the District of Columbia. Among the *amici* on whose behalf this brief is filed are a former directors of mental health and mental retardation from the state of Georgia and former commissioners or directors from several states that have joined the *amicus* brief on behalf of the petitioners, including Colorado, Hawaii, Indiana, Louisiana, Mississippi, South Carolina, Tennessee, Texas, and Wyoming.<sup>2</sup> These former state commissioners and directors of developmental disability and/or mental health have been involved with every aspect

<sup>1</sup> The parties have consented to the filing of this brief under S. Ct. Rule 37.2 and their letters of consent have been lodged with the Clerk of the Court. Pursuant to S. Ct. Rule 37.6, *amici* state that counsel for a party did not author this brief in whole or in part and that no one other than *amici* or their counsel made a monetary contribution to the preparation or submission of this brief.

<sup>2</sup> Biographies of the 58 former commissioners and directors on whose behalf this brief is filed are attached to the brief as Appendix A.

of their respective state service systems, from making budgetary decisions to overseeing the closing of institutions and the development of new community care alternatives, to tackling challenges posed by local community groups and unions. *Amici* strongly support community services in integrated settings as the best method of treating the majority of people with disabilities.<sup>3</sup> *Amici* believe that the Court of Appeals' decision should be affirmed and that enforcement of the Attorney General's integration regulation will not impose unreasonable financial or administrative burdens on the states. In fact, the position of *amici* is that, in situations in which mental health professionals recommend that individuals receive treatment in the community, such treatment is more appropriate, more effective, and less costly for the states.

### SUMMARY OF ARGUMENT

The Eleventh Circuit's decision to enforce the Attorney General's integration regulation will not profoundly change the way states are providing care to their citizens with disabilities.<sup>4</sup> Instead, it will result in more cost-effective and better quality systems of care. The Americans with Disabilities Act ("ADA") prohibits as discriminatory the unnecessary segregation of individuals with disabilities in institutions when, as here, their treating profes-

<sup>3</sup> Essentially, the term "integrated setting" means a community setting, as opposed to an institutional setting. See 35 C.F.R. Pt. 35, App. A, § 35.130 (ADA regulations define an integrated setting as one "that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible"). This term is well understood in the mental health and developmental disability fields. Community treatment in an integrated setting generally includes residential services like a group or family home, treatment and habilitation services such as assistance with acquiring, retaining and improving daily living, socialization and adaptive skills, and support services like home health aides, self-help groups and family supports. See CONGRESSIONAL RESEARCH SERVICE, SUBCOMMITTEE ON HEALTH AND ENVIRONMENT OF THE COMMITTEE ON ENERGY AND COMMERCE, MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 387 (Jan. 1993).

<sup>4</sup> Throughout this brief, the term "with disabilities" refers to both people with developmental disabilities and people with psychiatric disabilities. Where further distinction between the two groups is necessary, such distinction will be made in the text.

sionals have concluded that they may be appropriately served in the community. In 1990, when Congress enacted the ADA, it was well established that providing care to qualified individuals with disabilities in community settings, as required by the integration regulation, would actually save the states money and result in better quality care.

The fact that the states have traditionally provided services to people with disabilities by confining them in large institutions does not make the integration mandate less compelling. The obligation to provide services to qualified individuals with disabilities in the community rather than in institutions will not significantly change the states' disability systems, both because institutions will remain a viable option when needed and, more importantly, because states already provide most of their disability services in the community. Furthermore, because the federal government provides substantial funding to assist states with the cost of community-based treatment and because institutional care is so much more costly than community care, the integration regulation will not impose unreasonable financial burdens on the states.

The ADA was enacted to rectify a long history of discrimination suffered by people with disabilities in this country. However, stereotypes about people with disabilities and local political and economic interests continue to influence how states treat these citizens. Unfortunately, such arbitrary factors, unrelated to issues of treatment or expense, have caused many states to resist the move to more community-based care, even where medically appropriate and economically sound. Because Congress intended the ADA to be a bulwark against disability discrimination, this Court should enforce that mandate by affirming the decision of the Court of Appeals.



## ARGUMENT

### I. COMMUNITY INTEGRATION DOES NOT IMPOSE UNREASONABLE BURDENS ON THE STATES.

Contrary to the alarmist claims of the petitioners and the *amici* states, enforcement and implementation of the Attorney General's integration regulation will not result in careless deinstitutionalization or impose unreasonable financial burdens on the states. Rather, the majority of states already use integrated settings to care for their citizens with disabilities and currently provide most of their disability services in the community. Moreover, there is substantial evidence that community-based care is less costly than institutional care, and in any event, federal funding is available to help the states defray costs that might be associated with moving qualified individuals to community care. In short, if this Court affirms the decision of the Court of Appeals, it will not substantially disrupt state mental health and developmental disability systems. Rather, the experience of the *amici*, the professional literature and studies in the field strongly suggest that it will improve the quality of care states provide and result in a more cost-effective method of delivering services to people with disabilities.

#### A. Community Integration Will Not Result in Improper or Careless Deinstitutionalization.

This case is not about "deinstitutionalization" in the sense of widespread closure of institutions and release of all patients into the community, whether qualified or not, with or without appropriate care. If this Court affirms the Eleventh Circuit's decision, it will not result in vast numbers of individuals with disabilities roaming the streets of the nation's cities, without sufficient care, treatment or residential placement. Although the petitioners and the *amici* states who support them here seek to portray the case this way, as part of a parade of horrors that will allegedly follow

if the Eleventh Circuit's decision is affirmed,<sup>5</sup> the ADA does not require states to undertake "massive deinstitutionalization," see *L.C. v. Olmstead*, 138 F.3d 893, 901 (11<sup>th</sup> Cir. 1998), and neither the respondents nor the *amici* urge such a result.

Instead, the respondents and *amici* maintain that, in the context of this case, enforcing the Attorney General's integration regulation simply requires that states provide community services *to institutionalized individuals who are deemed qualified for and appropriate to receive such services by their treating professionals*. The argument of the respondents, already adopted by both the district court and the Eleventh Circuit, as well as by other federal courts to have considered this issue, see, e.g., *Cable v. Dept. of Developmental Services of the State of Calif.*, 937 F. Supp. 937 (C.D. Cal. 1997); *Charles Q. v. Houston*, 1997 U.S. Dist. Lexis 17305 (M.D. Pa. 1997); *Kathleen S. v. Dept. of Public Welfare*, 10 F. Supp.2d 476 (E.D. Pa. 1998); *Williams v. Wasserman*, 937 F. Supp. 524 (D. Md. 1996), is that keeping an individual in an institution once a treating professional has determined that the individual could be treated in an integrated setting constitutes unnecessary segregation in violation of the ADA. The Court of Appeals explicitly adopted this position:

[O]ur holding does not mandate the deinstitutionalization of individuals with disabilities. Instead we hold that where, as here, a disabled individual's treating professionals find that a community-based placement is appropriate for that individual, the ADA imposes a duty to provide treatment in a community setting – the most integrated setting appropriate to that patient's needs. Where there is no such finding, on the other hand, nothing in the

<sup>5</sup> See, e.g., Brief for Petitioners at 2 ("This is not the first national effort to impose a one-size-fits-all solution to an intricate medical problem – here, institutionalization versus deinstitutionalization of medical care."); *Amicus Curiae* Brief of the States in Support of Petitioners ("States' Brief") at 2 ("The overall thrust of this litigation is toward massive deinstitutionalization, regardless of the disruption and regardless of the short-term costs.") and at 4 (characterizing the respondents' argument as requiring "an immediate transition...to a community setting for each and every individual for whom it [is] a theoretical possibility").

ADA requires the deinstitutionalization of that patient.

*L.C.*, 138 F.3d at 901. In light of the clear language of the Court of Appeals, *amici* vigorously dispute the apocalyptic claims of the *amicus* states that enforcing the integration regulation will result in the careless release of large numbers of individuals with disabilities into the community without proper care and support. States' Brief at 4.<sup>6</sup>

### B. States Already Provide Most Disability Services in the Community.

More importantly, states are already moving in the direction of using community services as the primary means of treating their citizens with disabilities, and they are experiencing great success with those programs. Therefore, the claim in the States' Brief that placement of qualified individuals in these existing programs would significantly change the states' disability systems is inaccurate. The statutes of many states, including Georgia and several of the *amicus* states, explicitly provide that qualified individuals with disabilities be placed in the community or in the least restrictive setting appropriate to their needs. *See* Brief of *Amicus Curiae* American Association on Mental Retardation, et. al. Therefore, the petitioners and the *amicus* states cannot complain that this Court's affirmance of the Eleventh Circuit's decision would impose unreasonable burdens on them when the integration regulation simply confirms a policy that many of the states' legislatures have explicitly enacted.

Furthermore, the clear trend throughout the country in the fields of developmental disability and mental health care is toward downsizing or closing institutions and providing care in integrated settings. For example, at least six states (Alaska, New Hampshire, New Mexico, Rhode Island, Vermont, West Virginia) and the Dis-

<sup>6</sup> As discussed further below, providing community care to qualified individuals with disabilities need not result in the complete elimination of state-run institutions. It will remain economically feasible for states to make institutions available for those individuals who need and choose such care.

trict of Columbia now provide *all* services to people with mental retardation in the community. *See* DAVID BRADDOCK, *THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES* (David Braddock, et al. eds., 5<sup>th</sup> ed. 1998) at 9 ("Braddock"). Since the late 1980s, states have closed or reduced in size more institutions than at any other time in history. Between 1988 and 1995, states closed more than 85 institutions for people with developmental disabilities, over three and one-half times more closures than in the previous twelve years. *See* K. Charlie Lakin and Robert Prouty, *Trends in Institution Closure*, IMPACT, University of Minnesota, Winter 1995-96 at 4 ("Lakin and Prouty").

There is an equally strong trend toward serving more individuals with mental illnesses in the community, although somewhat fewer state-run psychiatric institutions have been closed. According to a survey of state mental health commissioners, "76% of the States are currently working to reorganize their State Psychiatric Hospital systems. The most common activities are downsizing existing hospitals, closing wards, reorganizing or reconfiguring one or more hospitals, [and] closing State hospitals." Web Site of the National Association of State Mental Health Program Directors (last modified Feb. 17, 1999), <<http://www.nasmhpd.org>> ("NASMHPD Web Site"). *See also* REINVESTMENT OF RESOURCES FROM FACILITY DOWNSIZING/CLOSURES TO COMMUNITY SERVICES: A COMPREHENSIVE REVIEW OF REINVESTMENT INITIATIVES (February 2, 1999) at 3 ("REINVESTMENT OF RESOURCES") (most state mental health authorities are actively reducing the size of state hospitals through either closure or downsizing). During the 1990s, states closed 37 state psychiatric hospitals, three times more closures than in the previous two decades combined. Opening Statement of A. Kathryn Power, Director, Rhode Island Department of Mental Health, Retardation and Hospitals, before U.S. Commission on Civil Rights, November 13, 1998, at 1-2 ("Power Statement"). Among the states actively downsizing state psychiatric hospitals are Georgia and several of the *amicus* states (Louisiana, South Carolina, and Wyoming). *See* Joint Appendix at 201; NASMHPD Web Site.

In addition to closing or downsizing institutions, states currently serve a greater number of individuals with disabilities in the



community than at any time in the past. The total number of people with developmental disabilities served in the community in the United States grew from fewer than 5000 in 1960 to more than 250,000 in 1996, while the institutional population decreased by more than 130,000 in the same period. Braddock at 26. In addition, all but two states reduced the number of individuals with developmental disabilities in institutions between 1992 and 1996. *Id.* Likewise, from 1970 to 1990, the number of beds available in state psychiatric hospitals decreased by nearly 50%. The state hospital population decreased from 186 residents per 100,000 in 1969 to 33 residents per 100,000 in 1992. See NASMHPD Web Site; Aileen B. Rothbard and Eri Kuno, *The Success of Deinstitutionalization: Empirical Findings from Case Studies on State Hospital Closures*, JOURNAL OF INTERNATIONAL LAW AND PSYCHIATRY, January 28, 1999 at 1.

The shift of dollars away from institutions and to community services further demonstrates the states' current commitment to community-based care. From 1992 to 1996, state spending for community services for individuals with developmental disabilities increased at an inflation-adjusted rate of 41%, or 9% per year. This compares to a 7% decline in institutional spending for developmental disabilities. By 1989, the amount of state money spent on community care exceeded the amount of funds allocated for institutions. See Braddock at 32. The same is true for mental health spending. In 1981, 63% of state mental health dollars were spent on institutional care. By 1993, expenditures for community-based services exceeded institutional expenditures. See NASMHPD Web Site (in 1993, states spent \$6.92 billion on community care, as compared to \$6.89 billion on institutional care). Between 1981 and 1993, state psychiatric hospital spending decreased by 24.5% and spending on community services increased by 44.1%. *Id.* See also UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH, UNITED STATES, 1996 (Ronald W. Manderscheid and Mary Anne Sonnenschein, eds., 1996) at 100 (the proportionate share of total state mental health expenditures for institutions changed significantly from 1969 to 1992; in 1969, spending on state-run hospitals represented 55% of total state mental health expenditures, as compared to 27% in 1992). The trend in Georgia is consistent with the national trend.

In recent years, the state has redirected dollars from developmental disability institutions to community services to the point where 57% of state funding went toward community services in 1997. Joint Appendix at 200-01.

### C. Federal Funding is Available to Assist States in Paying for Community Care.

Because the funding for community-based services does not come from the states alone, full implementation of the Attorney General's integration regulation will not create economic hardship for the states. The federal government has long provided a portion of state funding for mental health and developmental disability services, and the percentage of federal funding has increased substantially with the move to community-based care. See REINVESTMENT OF RESOURCES at 10 ("[m]any studies have noted the shifting of mental health care costs to the [f]ederal government through Medicare and Medicaid"); Braddock at 33 (in 1996, federal funding represented over 43% of all funding for community-based services for people with developmental disabilities); Mental Health, United States, 1996 at 102 (in 1992, federal funding represented 31% of all spending for treatment of the mentally ill, compared to 40% from state funds). The structure of federal funding programs now clearly favors community treatment. See Braddock at 34 (citing the federal Medicaid Home and Community-Based Services waiver program as a central reason federal funding for developmental disability community services increased by more than 18% per year throughout the 1980s); Mental Health, United States, 1996 at 103 (federal legislation promotes community-based services to the exclusion of state hospital services); Aileen B. Rothbard, et al., *Unbundling of State Hospital Services in the Community: The Philadelphia State Hospital Story*, 24 ADMINISTRATION AND POLICY IN MENTAL HEALTH 391, 396 (May 1991) (providing services in the community to individuals previously institutionalized at Philadelphia State Hospital created a 300% increase in federal participation in the care of those individuals because of structure of federal funding programs). By allowing states greater flexibility in how they can use federal funds to pay for mental health and developmental disability care and creating programs that are targeted toward community-based services,

the federal government has substantially eased the economic burden of providing care to people with disabilities.

The most important funding mechanism for community care for people with developmental disabilities is the Home and Community-Based Services ("HCBS") waiver program under the Medicaid program, in which all fifty states participate. *See* Braddock at 10. This program allows states to use Medicaid money to provide services in the community to individuals with developmental disabilities who would otherwise be treated at a higher cost in institutional settings. *See* 42 U.S.C. § 1396n(c)(1); 44 C.F.R. § 441.300 (the waiver program "permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization"). The HCBS waiver program has enabled states to move institutionalized individuals to less expensive community-based settings.<sup>7</sup>

States have used the HCBS waiver program to move countless individuals with developmental disabilities out of institutions. Indeed, the waiver program is no longer an alternative to institutionalization, it is now the primary means of serving people with developmental disabilities. *See* GARY A. SMITH AND ROBERT M. GETTINGS, *THE HCB WAIVER AND CSLA PROGRAMS: AN UPDATE ON MEDICAID'S ROLE IN SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES IN THE COMMUNITY* 14-15 (October 1994); Gary A. Smith, et al., *The HCB Waiver Program: The Fading of Medicaid's "Institutional Bias,"* MENTAL RETARDATION 262 (August 1996) (since 1992, the number of in-

<sup>7</sup> Under the Medicaid program, nearly all state institutions for people with developmental disabilities are categorized as "intermediate care facilities for individuals with mental retardation" (ICF/MRs). *See* 42 U.S.C. §§ 1396d(a)(15), 1396d(d); 42 C.F.R. § 440.150. Under Medicaid, the cost of these facilities is shared by the federal government and the states according to a statutory formula. The formula produces, for each state, the specific percentage of the cost that the state will pay and the "federal match," the specific percentage that the federal government will pay. The federal match generally covers from 50 to 75 percent of the cost of ICF/MR services, and state funding is used to finance the remainder of the costs. The federal match is the same for both HCBS waiver services and ICF/MR services.

dividuals served by HCBS waiver programs has been increasing at an annual rate of 29.2%, while the number of individuals served in ICF/MRs declined by 7.2% between 1992 and 1995).<sup>8</sup>

For individuals with mental illness, federal Medicaid money is also available to the states to fund virtually all mental health services in the community, including psychiatric rehabilitative services, outpatient clinic services, case management, prescription drug services, and personal care services. *See* 42 U.S.C. §§ 1396d(a)(12), (13), (19), (14); 1396n(g); 42 C.F.R. §§ 440.90, 440.130, 440.167.<sup>9</sup> While Medicaid funding is available for community mental health services, state psychiatric hospitals are generally ineligible to receive Medicaid funding. *See* 42 U.S.C. § 1396d(a)(B). Therefore, it is financially advantageous for states to shift the provision of mental health services from state institutions to integrated settings. In addition, managed care options available under Medicaid give states discretion to implement innovative packages of community mental health services designed to reduce hospitalization. *See* 42 U.S.C. § 1396n(b).<sup>10</sup> These options make

<sup>8</sup> States actually save money by providing services in integrated settings to previously institutionalized individuals through the HCBS waiver program. Because the cost of community care is significantly less than the cost of institutional care, and the federal government contributes the same percentage of funding for each, states can provide services to a greater number of individuals with developmental disabilities at a smaller overall cost to the state.

<sup>9</sup> The federal match for these services is the same as the federal match for HCBS waiver services.

<sup>10</sup> Since 1990, when the ADA was enacted, the U.S. Department of Health and Human Services ("HHS") has become increasingly more permissive in granting states flexibility through the use of HCBS waivers and managed care waivers in their Medicaid programs. *See, e.g.,* GARY A. SMITH AND ROBERT M. GETTINGS, *THE HCB WAIVER AND CSLA PROGRAMS: AN UPDATE ON MEDICAID'S ROLE IN SUPPORTING PEOPLE WITH DEVELOPMENTAL DISABILITIES IN THE COMMUNITY*, B4 (October 1994) (describing various Congressional amendments to the waiver program loosening restrictions on obtaining waivers); Gary A. Smith, et al., *The HCB Waiver Program: The Fading of Medicaid's "Institutional Bias,"* MENTAL RETARDATION 262, 262-63 (Aug. 1996) (rapid growth of HCBS waiver programs between 1990 and 1996 a result of, among other things, federal administrative policy changes affording states greater latitude to expand waivers and cover a wider range of services); RESEARCH AND TRAINING CENTER ON COMMUNITY LIVING, INSTITUTE ON COMMUNITY INTEGRATION/UAP, RESIDENTIAL SERVICES



community-based services even more attractive from a fiscal standpoint.<sup>11</sup>

Because considerable federal money is available to help states fund community-based services for both people with developmental disabilities and mental illnesses, any costs associated with the transition to increased community care will not fall primarily on the states. Moreover, even if certain short-term costs were to fall on the states, this would not justify a refusal to provide community care to qualified individuals when such care is recommended by their treating professionals. Congress specifically contemplated imposing certain costs on the states and determined that such costs would not constitute a reason for non-compliance with the Act. The House Report on the ADA stated explicitly that "[t]he fact that it is more convenient, either administratively or fiscally, to provide services in a segregated manner, does not constitute a valid justification for separate or different services under...this title." H.R. REP. NO. 101-485 (III) at 49-50 (1990), *reprinted in* 1990 U.S.C.C.A.N. 472-73. *See also* 135 CONG. REC. S4986 (daily ed., May 9, 1989) (statement of Senator Harkin)("Costs do not provide the basis for an exemption from the basic principles in a civil rights statute, like the ADA").

Courts have interpreted the ADA in a manner consistent with this legislative history. As a general rule, courts have held that "[i]nadequate state appropriations do not excuse noncompliance" with the ADA. *L.C.*, 138 F.3d at 904, *quoting Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 396 (5<sup>th</sup> Cir. 1980). Thus, courts have forced states to fund compliance with the ADA regardless of the budgetary constraints facing those states. *See, e.g., Concerned Parents to Save Dreher Park Center v. City of West Palm Beach*, 846 F. Supp. 986, 993 (S.D. Fla. 1994) (city must

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FOR PERSONS WITH DEVELOPMENTAL DISABILITIES: STATUS AND TRENDS THROUGH 1997 (Robert Prouty and K. Charlie Lakin eds., 1998) at 67 (cost neutrality requirements have been "considerably relaxed" since 1992).

<sup>11</sup>Other sources of federal funding are also available for community-based mental health services, such as federal block grant money for community mental health centers, *see* 42 U.S.C. §§ 300x *et seq.*, and federal subsidies for housing and support services. *See* 42 U.S.C. §§ 8011-8013.

continue to fund recreational programs for the disabled regardless of budgetary constraints; ADA's mandate that local governments provide equal opportunities for the disabled outweighs the public interest in having a balanced budget); *Kroll v. St. Charles County, Missouri*, 766 F. Supp. 744, 753 (E.D. Mo. 1991) (court justified in ordering an increase in property taxes in order to fund the changes necessary to make county courthouse handicapped accessible). These cases are consistent with the generally-accepted principle that the increased costs of complying with an anti-discrimination mandate do not constitute a valid excuse for failing to comply with that mandate. *See, e.g., Int'l Union, United Automobile Workers of America v. Johnson Controls, Inc.*, 499 U.S. 187, 210 (1991) ("the incremental cost of hiring women cannot justify discriminating against them" under Title VII).

#### D. Community Care Costs Less than Institutionalization.

Numerous studies comparing the costs and benefits of community care to institutionalization have concluded that community care is the more cost-effective way to provide services to people with disabilities. The annual cost of supporting an individual in the community under an HCBS waiver program is less than one-half the cost of treating that individual in an ICF/MR. *See* Smith and Gettings at 18. A study conducted for the American Journal of Mental Retardation in 1995 concluded not only that providing care to individuals with mental retardation in the community was more cost-effective than institutionalization, but also that state-owned institutions were the *most* costly mechanism for providing services. Edward M. Campbell and Laird W. Heal, *Government Cost of Providing Services for Individuals with Developmental Disabilities: Prediction of Costs, Rates, and Staffing by Provider and Client Characteristics*, AMERICAN JOURNAL OF MENTAL RETARDATION, July 1995 at 17-35. A study of the costs of treating 321 formerly institutionalized individuals with psychiatric disabilities in the community found that community-based services cost less than one-half as much as institutional care. Aileen B. Rothbard, et al., *Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A Three-Year Follow Up*

*Study*, AMERICAN JOURNAL OF PSYCHIATRY, December 9, 1998, at 2, 16 (total treatment cost in the community, including the cost of housing, was \$60,000 per person per year, compared to \$130,000 per person per year for institutional care). *See also* Herbert Bengelsdorf, et al., *The Cost Effectiveness of Crisis Intervention: Admission Diversion Savings Can Offset the High Cost of Service*, 181 J. NERVOUS & MENTAL DISEASE 757 (1993) (documenting considerable cost savings achieved by community-based services for individuals who otherwise would have been hospitalized).

In addition to being more expensive than community care, the cost of institutional care is rising. "During the 1992-96 period, the national average institutional daily costs [for people with developmental disabilities] advanced from \$210 to \$258." Adjusted for inflation, this represents a 10% increase over a five-year period. Braddock at 27. *See also* Lakin and Prouty at 4 (average annual state institution costs in 1980 were approximately \$30,000; by 1994, that cost had increased to approximately \$82,000). The cost of treating people with mental illnesses in institutions is also increasing. *See* REINVESTMENT OF RESOURCES at 2 (the rising cost of inpatient care at state psychiatric facilities has caused states to explore alternative community-based treatment).

A major reason that institutional care is so much more expensive than community care is the high cost of overhead. As total care environments, institutions must recreate many of the services that are part of the background of daily life. Thus, the provision of services in institutional settings "requires significant additional expenditures for facility and vehicle maintenance, utilities, and other fixed costs for the operation of separate facilities, as well as compensation for a workforce of cafeteria workers, janitors, and bus drivers." Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMP. L. REV. 393, 464 (Summer 1991). Moreover, many institutions are aging and require significant capital expenditures to maintain. In the report issued in connection with the closure of a state-run hospital for people with developmental disabilities in Georgia, the state noted that it cost more than \$3.3 million each year just to maintain the hospital's buildings. Joint Appendix at 171. Developing community-based

services need not and generally does not require construction of new facilities. While large institutional facilities inevitably involve high construction and maintenance costs, developing community-based services is generally accomplished by simply making funding available to service providers to lease houses or other real estate.

Because community services are significantly less expensive than institutional care, states actually save money when they provide greater services in integrated settings. The savings are greatest in the case of individuals with developmental disabilities because of the widespread use of the Medicaid Home and Community-Based Services waiver program. Nationally, "[t]he average annual cost of supporting an individual in the HCB[S] waiver program is \$33,444 versus \$67,681 in the ICF/MR program." Smith and Gettings at 17-18. *See also* STATE OF OREGON, DEVELOPMENTAL DISABILITY HCB WAIVER APPLICATION, FY 1999-2004 (Oct. 1998), at App. G-6 (in 1999, the cost to the state of Oregon to serve a developmentally disabled person in the community is projected to be \$39,465, while it would cost \$99,930 to serve that same person in an institution). When states use HCBS waiver slots to move individuals from institutions to the community, they actually save money and are able to provide services to a greater number of disabled people. *See* Joint Appendix at 181 (state of Georgia will save money by closing institution for people with developmental disabilities, permitting the state to provide community services not only to all former institutional residents but also individuals on waiting lists for those services).<sup>12</sup>

<sup>12</sup> While many states are taking advantage of the savings potential of the waiver program, some states, including Georgia, could be realizing even more savings. Under the statutory scheme, states are permitted to determine how many individuals they will serve in their waiver programs, and HHS approves funding for that number of waiver participants. *See* 42 U.S.C. § 1396n(c). However, there are many states, including Georgia, that are not making full use of the waiver program that HHS has approved for those states. For example, as of 1996, Georgia had used only 700 out of 2100 slots eligible for Medicaid waiver funding. *See* Joint Appendix at 93. Thus, Georgia could have moved 1400 more people, including the respondents, from institutions to the community and could have saved money in the process. *See* Joint Appendix at 89.



The experience of individual states is instructive. The record in this case reflects that the average daily cost to treat an individual with a developmental disability in an institution in Georgia is \$267, compared to a daily cost of \$106 to \$181 to treat the person in the community. Joint Appendix at 171. In its current multi-year plan for the provision of services to people with mental retardation, the Commonwealth of Pennsylvania estimates that moving from institutionalization to more community-based care will save the state \$105 to \$140 million over a five year period. See PLANNING ADVISORY COMMITTEE TO THE OFFICE OF MENTAL RETARDATION, PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE, A MULTI-YEAR PLAN FOR PENNSYLVANIA'S MENTAL RETARDATION SERVICE SYSTEM (July 1997) at 11 ("Pennsylvania Multi-Year Plan"). In 1995, the state of Maryland estimated that closing an institution for people with developmental disabilities and placing the 165 residents in integrated settings would save the state \$1.2 million in 1996 and \$6.1 million in 1997. See DEVELOPMENTAL DISABILITIES ADMINISTRATION, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, OPERATING BUDGET ANALYSIS (Feb. 8, 1995) at 19.

In Massachusetts, a commission appointed by the Governor found that providing care to both people with mental illnesses and developmental disabilities in community-based residential settings is a "highly desirable, highly effective, and less expensive" means of care. GOVERNOR'S SPECIAL COMMISSION ON CONSOLIDATION OF HEALTH AND HUMAN SERVICES INSTITUTIONAL FACILITIES, ACTIONS FOR QUALITY OF CARE (June 1991) at v. The Commission recommended closing and/or downsizing several state-run facilities and expanding community-based care. The Commission determined:

As a budgetary matter, the Commonwealth will realize substantial savings by placing appropriate consumers in residential settings. The costs for institutional services at mental health and mental retardation facilities can be \$100,000 per year per consumer. Community residential care ranges between \$30,000 and \$70,000, with an average annual per bed cost of \$55,000 for the provision of

residential day services as well as costs associated with real estate.

*Id.* at 29. The Commission ultimately determined that "[o]nce fully implemented, the net savings to the state are anticipated to be approximately \$60 million annually." *Id.* at vii.

The fact that community-based services are less costly than institutional care is further demonstrated by the factual findings made by the district court in this case. The court found that Georgia could provide services to L.C. and E.W. "at considerably less cost than is required to maintain them in an institution." As the court stated, "[t]he record establishes that, on an annual basis, institutional care for the mentally retarded costs more than twice as much as community care, and the same is true for the mentally ill." *L.C. v. Olmstead*, 1997 WL 148674, \*4 (N.D. Ga., March 26, 1997). See also *Helen L. v. DiDario*, 46 F.3d 325, 338 (3<sup>rd</sup> Cir.), cert. denied, 516 U.S. 813 (1995) (court found that moving the plaintiff from institutional to community care would save the state \$34,500 per year).

In addition, the cost-saving potential of caring for qualified individuals with disabilities in community settings was well documented when Congress enacted the ADA in 1990. For example, in its 1983 report, from which Congress derived key findings issued in conjunction with the ADA, the U.S. Civil Rights Commission stated, "[v]irtually all the relevant literature documents that segregating handicapped people in large, impersonal institutions is the most expensive means of care. Evidence suggests that alternative living arrangements allowing institutionalized residents to return to the community can save money." UNITED STATES COMMISSION ON CIVIL RIGHTS, ACCOMMODATING THE SPECTRUM (1983) at 78 (footnotes omitted). See also David Braddock, et al., *Synthesis of Research on the Costs of Institutional and Community-Based Care*, JOURNAL OF MENTAL HEALTH ADMINISTRATION 171, 172-74 (Fall 1990) (describing several studies that found community care for people with developmental disabilities to be less costly than institutional care); Laird W. Heal, *Institutions Cost More Than Community Services*, AMERICAN JOURNAL OF MENTAL DEFICIENCY 121, 136 (1987) (1986 per diem institutional cost for a person with developmental disability was \$127, compared with

\$81 for community-based care). In 1984, Congress itself heard evidence of the cost savings incurred by moving individuals into the community. See Joint Hearing on Recommendations to Improve Services for Mentally Retarded Citizens before the Subcommittee on the Handicapped of the Senate Committee on Labor and Human Resources and the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies of the Senate Committee on Appropriations, 98<sup>th</sup> Cong. 48 (1984) (statement of Sen. Weicker) (institutional care is "the most expensive care that you can give") and (statement of Ronald Melzer, director of Vermont Community Mental Retardation Programs) (based on experience in Vermont, "we can conclude that on a system-wide basis, community services are less costly than institutional care").

Community-based care is also more cost-effective than institutional care because of the positive benefits for those individuals treated in the community. Because these individuals interact with non-disabled people, learn job skills and learn how to cope in the "real world," they can cease to be an economic drain on society and instead become productive citizens who are more likely to achieve their full potential. Introducing the ADA in the Senate in 1989, Senator Harkin made a similar point:

[focusing] on the costs of compliance by covered entities totally misses the bigger picture. The economic benefits to society in terms of reductions in the deficit from getting people off of welfare, out of institutions, and on to the tax rolls cannot be ignored. This bill must be part of our overall strategy to get our Nation's economic house in order.

135 CONG. REC. S4986 (daily ed., May 9, 1989). Maintaining potentially productive individuals in institutions not only imposes the costs of care on the states but also imposes the costs of keeping individuals in "unjust, unwanted dependency." Cook, 64 TEMP. L. REV. at 458, citing Americans with Disabilities Act: Hearing Before the Senate Committee on Labor and Human Resources and the Subcommittee on the Handicapped, 101<sup>st</sup> Cong. 66 (1989) (statement of Mr. Dart). See also 135 CONG. REC. S10,798 (daily ed., Sept. 7, 1989) (statement of Senator Simon) ("[T]here is simply no way to put a price tag on the lost dignity and independence

of people who want to be contributing members of their families, their communities, and their country."). Thus, Congress clearly understood that while the ADA might impose short-term costs on the states, the long-range effects of integration would create more productive citizens and benefit society as a whole. See Cook, 64 TEMP. L. REV. at 465.

Making the transition from institutional to community-based care will not impose additional costs on the states because most states have the necessary structures in place to make this transition. For example, all states require periodic evaluations to identify individuals who do not need institutional care and provide appropriate discharge planning for them, both as a matter of professional standards and as a matter of system planning. See, e.g., GA. CODE ANN. §§ 37-3-64, 37-3-91; HAW. REV. STAT. § 333F-6. This information allows states to determine the types of services needed in the community and the approximate cost of those services. With such information, states are able to plan to downsize institutions in a cost-effective manner without admitting new individuals to fill the empty institutional beds. Many states have already transitioned from institutional to community-based care and, therefore, have gained substantial experience with such planning mechanisms. Pennsylvania's five-year plan for reshaping its mental retardation system is a prime example. In that plan, a state commission spelled out the steps necessary for the state to move effectively to more community-based care. The plan includes eight detailed recommendations including how the state can unify its system of funding mental retardation services, convert ICF/MR funding to HCBS waiver funding, and "[s]hift priorities for resource allocation from facility-based programs to services that build on natural supports." See Pennsylvania Multi-Year Plan at 6-12.

Moreover, states that have closed existing institutions as part of the transition to providing more care in the community have found creative ways to recover fixed costs invested in land and buildings. States have been very successful at converting closed institutions to alternative uses such as correctional facilities, juvenile detention centers, and other facilities for public uses. Lakin and Prouty at 5. See also Braddock at 28-29. Vast expanses of



public land on which institutions previously stood have been made available for local economic development, private industry, recreation and other local uses. For example, in Kansas City, Missouri, a state institution for the mentally retarded was converted into office space for use by other state government agencies, *see* Braddock at 29, and in Indiana, a state-run hospital was converted into a special treatment correctional facility. *See State to Close New Castle Center*, THE INDIANAPOLIS STAR, July 24, 1997, at B1. "Of all alternative uses, it seems at present the one of greatest favor is as correctional facilities. Corrections is a major growth industry in the United States, and offers substantial employment opportunities of similar pay and benefits to persons with backgrounds similar to the direct care staff of state institutions." Lakin and Prouty at 5.

Finally, although the move to community-based care may ultimately result in the closing of some state-owned institutions, it will not endanger the quality of care in the institutions that remain open. Instead, moving qualified disabled individuals, who do not need the restrictive care characteristic of institutions, into community care will likely improve the quality of care for those who remain institutionalized. The institution's treating professionals will be better able to provide appropriate care to fewer residents. In addition, although a smaller institutional population could increase the daily cost of an individual's care, the downsizing of the institution has a countervailing effect on its total budget. Thus, even when per capita costs increase, the reduction in total institutional population permits the institution to remain economically viable.

By requiring that individuals receive services in the most integrated setting appropriate to their needs, the Attorney General's integration regulation ensures that all types of care are available to people with disabilities. Because most states have already embraced the policy behind the integration regulation and currently provide most services for people with disabilities in integrated settings, enforcing the integration regulation will neither result in a significant change in state mental health or developmental disability systems, nor will it impose an unreasonable financial burden on the states.

## II. RESISTANCE TO COMMUNITY INTEGRATION IS THE RESULT OF HISTORIC DISCRIMINATION AGAINST PEOPLE WITH DISABILITIES, WHICH IS PRECISELY THE SOCIAL ILL THE ADA AND THE INTEGRATION MANDATE WERE MEANT TO CORRECT.

Congress enacted the ADA in 1990 against the backdrop of a long history of discrimination against people with disabilities. Despite the petitioners' attempt to gloss over this unfortunate history, *see* Petitioners' Brief at 3-6, this Court has recognized that this country has subjected people with disabilities to shameful and humiliating treatment for hundreds of years. *See, e.g., City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 461 (1985) (Marshall, J., concurring in part and dissenting in part) ("the mentally retarded have been subject to a 'lengthy and tragic history' of segregation and discrimination that can only be called grotesque") (citations omitted). One of the most prevalent forms of discrimination against people with disabilities was, and still is, to segregate them from the rest of society by unnecessarily confining them in state-run institutions. Congress intended the ADA to end this form of discrimination, as well as all forms of discrimination suffered by individuals with disabilities. *See* 42 U.S.C. § 12101(a)(2) ("historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem"); 42 U.S.C. § 12101(b)(1) ("It is the purpose of this chapter to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."). The knee jerk opposition of the *amicus* states to the Eleventh Circuit's decision in the face of substantial evidence of the positive benefits of integration is likely caused by several factors, and is, at least in part, a piece of the legacy of discrimination against people with disabilities.

The overwhelming consensus of mental health professionals, including the *amici*, is that most individuals with developmental

disabilities and mental illnesses can be better treated in the community than in institutions. As David Braddock explained in his summary of state services for people with developmental disabilities:

[t]he efficacy of community living is grounded in research. Positive changes in functional skills or adaptive behaviors have been documented in numerous community integration studies and in the behavior analysis literature. Studies of family attitudes have also indicated that the great majority of parents of formerly institutionalized persons with mental retardation are consistently satisfied with the benefits of their relative's community living experience.

Braddock at 12. A study of the effects of deinstitutionalization on people with mental retardation concluded, based on eighteen studies conducted between 1976 and 1988, that people who move from state institutions to small community settings experience increased development in functional and adaptive skills. Sheryl A. Larson & K. Charlie Lakin, *Deinstitutionalization of Persons with Mental Retardation: The Impact on Daily Living*, JOURNAL OF ASSOCIATION OF PERSONS WITH SEVERE HANDICAPS 324 (March 1989). In fact, the state of Georgia has itself acknowledged the benefits of community care for treating people with developmental disabilities. In the written description accompanying the closure of a state-run institution, the Georgia Department of Human Resources noted:

[m]ore than 50 studies nationwide and our own experience in Georgia show that people with mental retardation who move from institutions to community services make dramatic gains. They learn a variety of daily living skills, have fewer behavior problems, usually have more contact with their families and are more satisfied.

Joint Appendix at 169-70.

The same can be said for treatment of people with mental illnesses. The "growing consensus within the mental health field [is]

that, whenever feasible, people with mental illnesses should receive services in a community, rather than institutional, setting." Power Statement at 2. As with individuals with developmental disabilities, those people with mental illnesses who are treated in the community function with "greater independence...[and] express far greater satisfaction with their living situation and overall quality of life." Elizabeth C. McDonel, et al., *Downsizing State Operated Psychiatric Facilities: Three New Research Efforts to Examine the Quality of Community Care for Persons with Severe Mental Illness* (National Association of State Mental Health Program Directors Research Institute, Fourth Annual National Conference Proceedings, Jan. 1994) at 20. See also id. at 22 ("the literature has continued to pile up in favor of community alternatives [for people with mental illnesses]....There is certainly very little evidence suggesting that...long term hospitalization is a good idea, and clear indications that it is actually harmful."); Rothbard and Kuno, JOURNAL OF INTERNATIONAL LAW AND PSYCHIATRY at 3-4 (describing several studies that found considerable improvement in social interaction and overall functioning level of formerly institutionalized people with mental illnesses receiving treatment in the community).

The experience of treating professionals included in the record is consistent with the findings of the national studies. See, e.g., Affidavit of Diane Cobb, Joint Appendix at 132 ("In my experience, persons with mental retardation and mental illness, especially if they have been frequently institutionalized, often have long-standing behavior problems which can be more effectively addressed in the community where the individual can form a consistent relationship with one or two trained staff in a supportive environment."). In sum, there is now a clear consensus among researchers and other professionals that services in community settings produce better results for individuals with disabilities than does institutional care. See Cook, 64 TEMP. L. REV. at 413; Braddock at 12-16.

Notwithstanding the treatment and cost benefits of community care compared to institutional care, the petitioners and the *amicus* states have objected strenuously to the enforcement and implementation of the integration regulation. The available evidence,



and the experience of the *amici*, suggests that there are several factors that likely explain the motives behind their objections. One likely contributing cause is historical discrimination against people with disabilities. *See Cleburne*, 473 U.S. at 461-65. An additional reason is the stigma surrounding mental illness, which has historically generated opposition to community placement in residential neighborhoods for both people with developmental disabilities and those with mental illnesses, further complicating the development of housing and employment opportunities. *See* Power Statement at 3. Community residents often resist efforts to create group homes for people with disabilities, contending that the disabled residents will engage in "unruly behavior," cause property values to decline, or harm other residents. Marianne Comfort, *Disabled Neighbors Joining in Daily Life*, AKRON BEACON JOURNAL, Feb. 2, 1997, at G3. *See also* *Finding a Place for the Mentally Ill*, BOSTON GLOBE, Jan. 31, 1996, at 12 ("nearby residents say they are afraid just to walk past the group home" for people with mental illnesses); John Richardson, *A Struggle to Fit In*, MAINE SUNDAY TELEGRAM, Dec. 1, 1996, at 1A (describing a community protest against an existing group home for individuals with mental illnesses in which a protester cut off a sewer line and filled the home with raw sewage, forcing the residents to evacuate).

This "not in my backyard" objection to community-based care was dramatically displayed in the city ordinance challenged in the *Cleburne* case. The City of Cleburne, Texas required a special zoning permit for a home for people with mental retardation that it did not require for other multiple occupancy dwellings. 473 U.S. at 436. One of the city's reasons for requiring the special permit was the "negative attitude" of the majority of property owners located near the proposed home and the fears of those residents. *Id.* at 448. This Court properly held that "mere negative attitudes, or fear, unsubstantiated by factors which are properly cognizable in a zoning proceeding, are not permissible bases for treating a home for the mentally retarded differently from apartment houses, multiple dwellings, and the like." *Id.*

Congress intended the ADA to dispel the fear and stereotypes about people with disabilities by encouraging interaction between disabled and non-disabled persons in daily life. One important

means of encouraging this interaction is by permitting qualified people with disabilities to live in community facilities, with appropriate care and support, surrounded by disabled and non-disabled people alike. Greater inclusion of people with disabilities benefits both disabled individuals and society as a whole. *See* 136 CONG. REC. H2603 (daily ed., May 22, 1990) (statement of Rep. Collins) ("To be segregated is to be misunderstood, even feared. If we have learned any lessons in the last 30 years, it is that only by breaking down barriers between people can we dispel negative attitudes and myths that are the main currency of oppression."); Cook, 64 TEMP. L. REV. at 448-49 ("It is well documented that when peers with and without disabilities receive accurate information about one another and are provided with opportunities to interact with one another on an ongoing basis, social acceptance occurs. The research demonstrates that these types of...interactions lead to greater tolerance for diversity and difference by persons without disabilities.").

Local economic and political interests are an additional reason states continue to overutilize institutions as one method of caring for people with disabilities, even in the face of the overwhelming evidence that community placement is preferred by treating professionals and is less costly. Often, influential state legislators whose constituents' jobs or profits depend on institutions prevent or delay downsizing or closure. *See* SUSAN STEFAN, *DISCRIMINATION AGAINST PEOPLE WITH PSYCHIATRIC DISABILITIES* (forthcoming 1999) at Ch. 9, n. 55 ("In Montana, the State Legislature resisted the efforts of the State Department of Institutions to close its facility for people with mental retardation openly on the grounds that even if closure would improve the lives of the residents at the institution, people in the surrounding area needed the jobs."). Labor unions have also been a vocal and influential force in keeping institutions open, even in the face of evidence demonstrating that closure might be sound economic and mental health policy. *See* Mental Health, United States, 1996 at 103 ("Confounding the options of policy makers are economic pressures brought by communities and labor unions to keep the state and county mental hospitals open [and] to increase their size."). Unions like the American Federation of State, County and Municipal Employees ("AFSCME") have often stridently resisted

state efforts to move to community care in order to protect its members' jobs. AFSCME has only supported the downsizing or closing of institutions in states where community services were to be provided by the state itself rather than by private providers, thereby protecting the jobs and wages of AFSCME members. See AFSCME PUBLIC POLICY DEPARTMENT, AFSCME AND THE MENTALLY DISABLED: INSTITUTIONS TO COMMUNITY CARE (June 1992) at 9.

While labor unions may have legitimate concerns about the stability of their members' jobs, a civil rights statute like the ADA and its implementing regulations cannot be held hostage to such political or parochial interests. The type of care to be provided to an individual should be determined by the individual's particular needs and his or her civil rights, not the desires of a labor union or any other interest group. The integration regulation, by requiring a state to provide services to an individual in the most integrated setting appropriate for his or her needs, properly implements this principle.

Finally, bureaucratic inertia is the reason for reluctance on the part of some states to embrace fully the mandate of the integration regulation. States have been caring for their citizens with disabilities in large institutions for more than one hundred years, and many institutional administrators have resisted making changes in the status quo. After all, providing services to individuals with disabilities in the community requires more commitment, creativity, and innovation than simply congregating large groups of individuals with vastly different disabilities in a few state-run institutions. The record in this case reflects that the state of Georgia took a long time to find community placements for the respondents largely because of neglect and bureaucratic inertia. See, e.g., Joint Appendix at 118-19 (series of memoranda over the course of four months describing lack of progress in finding treatment for E.W. in the community).<sup>13</sup>

<sup>13</sup> Another example of such inertia was noted by the court in *Helen L.*, 46 F.3d at 337-38, in which the state offered "administrative convenience" as a reason for not placing the plaintiff in community care.

In sum, the Attorney General's integration regulation is a reasonable construction of the ADA that will not have catastrophic financial implications for states that might have to increase the speed with which they transition to community treatment. Nor will it have dramatic social implications in the form of the careless release of severely ill individuals into the community without proper care and support. Instead, it represents sound civil rights, mental health and fiscal policy, and it reflects the direction in which the majority of state providers of care are already moving. The factors that contribute to the *amicus* states' and the petitioners' opposition to the Eleventh Circuit's decision, such as past discrimination, local political and economic interests and bureaucratic inertia, are unacceptable reasons to keep potentially productive citizens unnecessarily confined to institutions and prevent them from reaching their full potential.

## CONCLUSION

The judgment of the Court of Appeals should be affirmed.

Respectfully submitted.

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MARCH 15, 1999



## APPENDIX

### Deborah Allness

Deborah Allness was director of the Wisconsin Office of Mental Health from 1986 to 1990. She was a co-developer of the PACT model, an intensive community-based treatment and rehabilitation program for persons with severe and persistent mental illness. She co-authored the groundbreaking manual, *The PACT Model of Community Based Treatment for Persons with Severe and Persistent Mental Illness*, which was sponsored by the National Alliance for the Mentally Ill. For Wisconsin, Allness wrote and promulgated standards for PACT-like programs and established it as a Medical Assistance (MA) benefit, creating a financial incentive for the state's counties to implement the program. Since her service in state government, Allness consults with states and providers in the development of community treatment and financing under MA and managed care.

### Dennis G. Amundson

Dennis Amundson served as California's Director of the Department of Developmental Services from 1991 through 1997. During this period, the Department successfully reduced the institutional population from 6,800 to less than 4,000. The reduction enabled the state to close two large state institutions and transfer cost savings to expand community-based options for persons with developmental disabilities. Between FY 1991-92 and FY 1997-98, California's community system grew from serving 103,000 individuals with developmental disabilities to more than 140,000. The community budget grew during this period from \$646 million to nearly \$1.2 billion, with nearly \$400 million of this increase generated from federal waiver authority.

### C. Patrick Babcock

For more than five years, Patrick Babcock served as the Director for the Michigan Department of Mental Health before becoming the Director of the Department of Social Services. As the state official responsible for the delivery of mental health services, Babcock oversaw community mental health services that included 55 community mental health boards serving all 83 Michigan counties. He also was responsible for community residential serv-

ices for former residents of state facilities for persons with mental illness and developmental disabilities. Babcock is the Director of Public Policy for the W.K. Kellogg Foundation, where his duties include serving as Project Director of a health reform project in three Michigan communities.

#### **Joseph J. Bevilacqua, Ph.D.**

Joseph Bevilacqua has twenty-one years experience as State Commissioner of Mental Health Services in Rhode Island, Virginia, and South Carolina. He also served as Assistant Commissioner for Community Services for four years in Virginia. Prior to state service, Bevilacqua served in the United States Army as a social work officer working in psychiatric hospitals and Mental Health Clinics both in the states and overseas. Throughout Bevilacqua's career he has been actively affiliated with a number of academic institutions, including appointments at the University of Virginia, Brown University, Medical College of Virginia, University of South Carolina, and Medical University of South Carolina. He used his state role to encourage collaboration between the University and Departments of Mental Health. This collaboration included research projects, student placements in state programs and faculty consultation in major state initiatives such as community development and hospital downsizing. He has also written a number of publications in the field of mental health.

A major priority of Bevilacqua's commissionership has been active and strong support of consumers of mental health services. He worked hard to actively engage them in advocacy as well as advisors to mental health providers, encouraged self-support and consumer independence, and strongly promoted consumers to be active and paid staff members to provider organizations including public mental health systems. Bevilacqua served two terms as President of the National Association of State Mental Health Program Directors and currently serves on the Board of Directors of the Human Services Research Institute, Boston; the Center for Study of Issues in Public Mental Health, Albany; Fellowship Health Resources, Lincoln, Rhode Island; The Green Door, a psychosocial rehabilitation program in Washington, DC; and National Alliance for the Mentally Ill-Rhode Island.

#### **Gerald A. Born**

Until January 1998, Gerald Born had been in state service for 27 years. He was variously the Director of the Wisconsin Bureau of Developmental Disabilities, Administrator of the Division of Community Services, and the Assistant Administrator in both the Division of Care and Treatment Facilities and the Division of Community Services. Born has also been a university faculty member and an administrator of both public and private facilities for people with mental retardation. In 1998, Born was hired as the Executive Director of The Arc-Wisconsin, a statewide advocacy organization that serves people who have developmental disabilities and their families.

#### **Geraldine Botwinick**

Geraldine Botwinick became the Acting Division Director of the New Jersey Department of Human Services Division of Mental Health and Hospitals after serving many years as the Deputy. During her tenure as Deputy and Acting Director, Botwinick developed a regionalization plan to reorganize and unify hospital and community mental health services and executed New Jersey's first contract for consumer-run services. Botwinick also spent three years as the Director of Community Services for New Jersey, managing the statewide community mental health system. In this position, she doubled the state funding base for community services by utilizing methods such as the state's first community capital bond issue and securing a federal Housing and Urban Development demonstration grant for the chronically mentally ill and a Community Support Grant from the National Institute for Mental Health. Botwinick is an independent consultant and owner of the Strategic Consulting Group.

#### **James Donald Bray, M.D.**

Donald Bray oversaw the Oregon Mental Health Division from 1971 to 1979. After retiring from Oregon state government in 1989, he was a Visiting Scholar with the South Carolina Department of Mental Health. He has served as a mental health con-



sultant to the National Institute of Mental Health and the following states: Illinois, Utah, Alabama, Idaho, and Kentucky. Bray currently works as a consultant to the South Carolina Public-Academic Mental Health Consortium and the Department of Mental Health. Bray's career has been primarily focused on developing community-based services for people with severe mental disorders and developmental disabilities.

#### **Philip Campbell**

Philip Campbell served as the Commissioner for the Massachusetts Department of Mental Retardation from 1991 to 1997. Campbell provided leadership during a major public policy transition to a community-based system of supports. His accomplishments included an increase in federal Home and Community Based Services waiver support from \$28 million in 1991 to \$133 million in 1997, closure of three public institutions, and completion of disengagement from 21-year-old federal court involvement in five federal consent decrees. Campbell's efforts reduced the state's net cost of serving persons with developmental disabilities by 6% while the number of persons served increased by 15%. Campbell is the Chief Executive Officer of Family Services of Western Pennsylvania.

#### **Robert L. Carl, Jr., Ph.D.**

During Robert Carl's approximately 17 years as head of Mental Retardation/Developmental Disabilities Services in Rhode Island, he created community alternatives for all institutionalized persons. Rhode Island was the first state to promulgate a policy to close all public Mental Retardation/Developmental Disabilities institutions. Under Carl's leadership, the state developed the most comprehensive community based system in the nation. All eligible persons receive service. There is no waiting list, and no persons are sent out-of-state for service. Prior to his position in Rhode Island, Carl was Deputy Commissioner for the Ohio Department of Mental Health and Mental Retardation. Carl currently serves as the Director of the Rhode Island Department of Administration and reports directly to the governor.

#### **Kevin W. Concannon**

Kevin Concannon became Commissioner of the Maine Department of Human Services in February 1995. He was previously Director of the Oregon Department of Human Resources for eight years and Administrator of the Oregon Mental Health and Developmental Disability Services Division for a period of months. From 1980 to 1987, he was Commissioner of the Maine Department of Mental Health and Mental Retardation and was Director of the Maine Bureau of Mental Retardation from 1977 to 1980. He worked for a number of years in private social welfare as Regional Administrator and Associate Director of a statewide social and health services agency.

Concannon has held a number of national leadership roles, including President of the National Association of State Mental Health Program Directors from 1987 to 1988. He was a member of the National Academy of State Health Policy Commission on Vulnerable Populations, is Chair of the New England States Consortium on Medicaid-Medicare dual eligible service populations, and was the Maine team leader for the Danforth Foundation Policy Makers Program. He has also served on various national advisory groups, such as the Joint Commission on Accreditation of Hospitals, the Kennedy School of Government at Harvard University's Advisory Group on Mental Health Leadership, and the State Human Resource Development Center Advisory Council at the National Institute of Mental Health.

#### **Robert J. Constantine**

Robert Constantine spent many years working in mental health for Florida state government.

He served as the State Mental Health Program Director in the early 1980's, was the chief administrator for several psychiatric facilities, and later returned to state government to serve as the State Director of Alcohol, Drug Abuse and Mental Health Programs. Constantine is the President and Chief Executive Officer for the Florida Council for Behavioral Healthcare.

### **King Davis, Ph.D.**

King Davis served as Commissioner of the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services from 1990 through 1994. During that period, a major priority of the department was the placement of individuals with disabilities in the community. A number of initiatives were developed to increase the success of community placements. The Commonwealth of Virginia's commitment to community placements extends as far back as 1968 with the development of the Community Services Act. Additionally, in response to efforts by the U.S. Justice Department to ensure compliance with the Civil Rights of Institutionalized Persons Act, the Governor, Attorneys General, and the legislature supported the Department of Mental Health's efforts to decrease its reliance on institutions in favor of community-based strategies of care. This strategy included specific placement of a fixed number of institutionalized residents with mental retardation at the Northern Virginia Training Center in local communities. This community-based strategy became the accepted policy direction of the Commonwealth of Virginia. Davis is the William & Camille Hanks Cosby Professor at Howard University.

### **Jan Duker, Ph.D.**

Jan Duker has worked professionally in the mental health and mental retardation fields for almost 40 years. During her career, she served as Executive Director of the Mississippi State Department of Mental Health and Mental Retardation from 1980 to 1986. Duker also spent five years as Executive Director of the Mental Health Mental Retardation Authority (MHMRA) of Harris County in Houston, Texas, the largest community-based authority in the country. Under Duker's leadership, MHMRA provided a full range of public mental health and mental retardation services, including residential services, in the 1,700 square mile county area.

In addition, Duker has chaired committees for the National Association of State Mental Health Program Directors and been a grant reviewer and state plan reviewer for the National Institute for Mental Health. She has also served as a consultant to states for

issues such as community services, managed care, and children's services.

### **Steven M. Eidelman**

As the Director of Pennsylvania's mental retardation/developmental disabilities program from 1987 to 1993, Steven Eidelman was responsible for leadership and management of all community and institutional services for 65,000 residents. During his tenure, he managed the largest Medicaid waiver for long-term care project in the United States. Eidelman also developed new programs and services in the areas of support services to families, early intervention and employment of persons with disabilities. He left state government to become Executive Director of the Joseph P. Kennedy, Jr. Foundation and also served as the Interim Executive Director of the American Association of University Affiliated Programs, a national trade association for 70 major research universities engaged in training, exemplary and demonstration service projects, and research in the fields of developmental disabilities and related disorders. Eidelman was recently named Executive Director of the national Arc, formerly the Association for Retarded Citizens of the U.S.

### **Eileen Elias, M.Ed**

Eileen Elias was the Commissioner of Mental Health for the Commonwealth of Massachusetts from 1991 to 1996, where she transformed the State's state hospital-based mental health system into a national model of an integrated, comprehensive community-based service system. In addition, she revamped and restructured public and private behavioral health acute and continuing care services to become organized systems of community-based care in the District of Columbia (1997, Acting Commissioner for the Commission on Mental Health Services); Massachusetts Department of Mental Health (1988 to 1991, Area Director and 1991 to 1996, Commissioner); New Jersey (1981 to 1983, Greater Trenton Mental Health Center Director of Case Management & 1984 to 1988, New Jersey Division of Mental Health, Central Region Director and State Director of Core Services); Rhode Island



(1983 to 1984, Kent County Community Mental Health Center, Chief of Community Support Services); and Pennsylvania (1971 to 1981, Horizon House Psychosocial Program, an array of positions inclusive of case manager, Director of Case Management).

Elias has published a breadth of publications on the subject of organizational change and is a recognized speaker and consultant on a variety of subjects relating to organizational change, facility consolidation, managed care, and consumer empowerment. She presents at regional, national and international workshops and conferences and is an invited speaker at academic institutions including Harvard University Kennedy School of Government and the Massachusetts Institute of Technology Sloan School. Elias is currently a Systems Consultant for the federal government's Substance Abuse and Mental Health Services Administration and CPC-Chestnut Lodge, a non-profit, nationally known psychiatric service center.

#### **Sue Elliott**

Sue Elliott was Director of the Washington State Division of Development Disabilities from 1987 to 1993 and the Planning and Evaluation Manager for Arizona's developmental disabilities agency from 1976 to 1980. During her tenure in state government, Elliot developed and implemented plans for the movement of over 700 persons out of state institutions and nursing homes into community alternatives. Other accomplishments include: developing and implementing plans to reduce state expenditures by \$8.2 million, as directed by Governor; negotiating successful agreements with state labor unions; gaining legislative approval for and directed implementation of the closure of one of three state-operated institutions in Arizona and Interlake School in Washington for the developmentally disabled; and expanding community-based system of services offering alternatives to institutionalization for persons who were developmentally disabled.

#### **Mary Jane England, M.D.**

As the first commissioner of the Massachusetts Department of Social Service (DSS) from 1979 to 1983, Mary Jane England

helped establish and administer a new state agency for children and their families. Before her appointment at DSS, she served as the Associate Commissioner of the Massachusetts Department of Mental Health and Mental Retardation.

In 1995, England served as president of the American Psychiatric Association, and she is a past president of the American Medical Women's Association. She serves as the Vice President of the National Academy of Public Administration, the American College of Psychiatry, the American College of Mental Health Administration, and the Group for the Advancement of Psychiatry.

England also served on the Board of Overseers for the U.S. Department of Commerce, Malcolm Baldrige National Quality Award and currently serves on the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration National Advisory Council and the National Institute of Mental Health Advisory Council. She currently serves on the President's Quality Forum Planning Committee.

England was also associate dean and director of the Lucius N. Littauer Master in Public Administration (MPA) Program at the John F. Kennedy School of Government, Harvard University. Dr. England is the chair of the Board of Visitors of Boston University School of Public Health and a member of the Board of Visitors of Boston University School of Medicine. England is president of the Washington Business Group on Health, a nonprofit national health policy and research organization whose membership includes the nation's major employers.

#### **David L. Evans**

From 1990 to 1993, David Evans was the Director for Georgia's Division of Mental Health, Mental Retardation and Substance Abuse. Prior to his service in Georgia, Evans was the State Director for the Office of Mental Retardation for Nebraska and Acting Director of the Community Services Division for Developmental Disabilities in Michigan. A past president of the National Association for State Mental Retardation Program Directors, Evans is the Executive Director of the Austin-Travis County Mental Health Mental Retardation Center in Austin, Texas.

### **Jaylon L. Fincannon**

As Director of Mental Retardation Services in Texas for 13 years, Jaylon Fincannon was instrumental in the development of a comprehensive community service system, improvements in state-operated facilities, closure of two state-operated institutions and dismissal of a 21-year-old class action lawsuit. He currently serves as a member of a three-person Quality Review Panel established in Tennessee to oversee the state's planned improvements in the community service system and three of the state's developmental centers. The Panel was established as part of the state's compliance with the Settlement Agreement of a class action lawsuit. Fincannon not only provides monitoring of the improvements, but also provides technical assistance to all aspects of the improvement process. He is also currently providing consultation to the Division of Services for People with Disabilities, Utah Department of Human Resources.

### **William Goldman, M.D.**

William Goldman is a former Commissioner of Mental Health and Mental Retardation for Massachusetts. He also served as the Director of Mental Health, Drug and Alcoholism Services for the city and county of San Francisco. Throughout his career in mental health, Goldman strived to provide services for people with mental illness in the least restrictive environment by attaching resources to the individual rather than the institution.

Goldman is currently the Senior Vice President for Behavioral Health Sciences at United Behavioral Health and a Clinical Professor of Psychiatry at the University of California, San Francisco. He serves on the University of California Los Angeles/Rand Research Center on Managed Care for Psychiatric Disorders Advisory Board and is a member of the National Institute for Mental Health Program Research Advisory Group and the Parity Workgroup. Goldman is also a member and immediate past Chair of the American Psychiatric Association Council on Economic Affairs.

### **Dennis Harkins**

From 1987 to 1997, Dennis Harkins was director for services to people with developmental disabilities in Wisconsin. He has been involved in the deinstitutionalization of people with developmental disabilities and in helping create community living for all people with disabilities since 1972. During his career in Wisconsin state government, Harkins developed and implemented creative and effective statewide programs for people with developmental disabilities that continue to serve as models for other states and countries. He currently remains active in working on this issue as a private consultant to local, state and national organizations.

### **Ken Heinlein, Ph.D.**

Ken Heinlein has more than 20 years experience in the field of developmental disabilities, including direct services to adults with developmental disabilities in community-based vocational and residential settings and eight years in the administration of Wyoming's developmental disabilities system serving infants, toddlers, and preschool aged children and adults with disabilities. In Wyoming, he served as Director of the Department of Health and Social Services and Director of Department of Health, both of which oversaw the department of developmental disabilities. Heinlein is the Director of the Outcome Research Center for the Wyoming Institute for Disabilities/University Affiliated Program at the University of Wyoming where he conducts research in post-institutional placements, including the cost and quality of community-based supports and services for persons with developmental disabilities.

### **Donald J. Hevey**

From 1982 to 1985, Donald Hevey served as the Director of the Alcohol, Drug Abuse and Mental Health Program Office for the State of Florida. In this position, he was responsible for directing, regulating and contracting for the statewide administration of all community alcohol, drug abuse and mental health programs and institutional mental health, substance abuse and forensic pro-



grams. He also served as the Assistant Director of this office in 1981 to 1982. Prior to his service in state government, Hevey served as the Chief Executive Officer of the Manatee County Community Mental Health Center in Bradenton, Florida, where he was responsible to a community board of directors for the management and administration of a comprehensive mental health and substance abuse center. Hevey presently serves as President and Chief Executive Officer of Mental Health Corporations of America.

#### **Elin Howe**

Elin Howe has 24 years of experience in the field of Developmental Disabilities, including almost four years as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities. As Commissioner, she was responsible for policy development, planning, financing, regulating, managing, and providing services to the approximately 75,000 New York State citizens with mental retardation and developmental disabilities. Howe has provided consultation services on developmental disabilities issues in five states including: New Mexico, Indiana, California, Iowa and Georgia. In addition, Howe has extensive experience in working with parents, consumer and advocacy group services, providers and boards of directors, community and legislative relations in human resources management, including labor relations, labor organizations, cultural diversity issues, in budgetary process and in development and implementation of total quality management initiatives.

#### **Jennifer L. Howse, Ph.D.**

Jennifer Howse has held a number of key executive positions in health-related organizations, including those of State Commissioner for Mental Retardation in Pennsylvania and Associate Commissioner in the New York State Office of Mental Retardation and Developmental Disabilities. After leaving state government in 1986, Howse joined the March of Dimes, serving as the Executive Director of the organization's Greater New York Chapter and becoming president of the March of Dimes Birth Defects Foundation

in 1990. She serves on the board of The Salk Institute for Biological Studies and chairs the Advisory Board of The Center for Family Life. She is a member of the Kaiser Commission on Medicaid and Uninsured, and the Advisory Committee to the Director, Centers for Disease Control and Prevention. Howse is the recipient of the Human Dignity Award from the Henry H. Kessler Institute and the Leadership in Health Care Award from the Pace University School of Nursing.

#### **Pamela S. Hyde, J.D.**

Pamela Hyde was appointed by Governor Richard F. Celeste as the Director of the Ohio Department of Mental Health, and later the Ohio Department of Human Services, the state's Medicaid and child welfare agency. She served as the Director of the Seattle Department of Housing and Human Services, and then was recruited as President and Chief Executive Officer of ComCare, a Phoenix-based behavioral health managed care company. Hyde is trained as an attorney and also spent several years as an advocate and executive director of a statewide protection and advocacy agency. Hyde is presently a Senior Consultant with the Technical Assistance Collaborative, Inc., a Boston-based non-profit organization founded by the Robert Wood Johnson Foundation to assist state and local governments and non-profit agencies meet the changing demands of the behavioral health, housing, child welfare, and human services fields.

#### **Dennis R. Jones, M.S.W., M.B.A.**

Dennis Jones was Commissioner of Mental Health in Indiana from 1981 until 1988. He was then Commissioner for the Texas Department of Mental Health and Mental Retardation for six years. Both of these positions included institutional and community responsibility for mental retardation as well as mental health.

#### **Martha Boatman Knisley**

Martha Knisley's 29 years of experience in mental health and mental retardation programs include serving as Commissioner of

Mental Health for the Commonwealth of Pennsylvania and as Director and Deputy Director of the Ohio Department of Mental Health, where she developed strategies for downsizing facilities. Presently, she is a senior consultant with the Technical Assistance Collaborative (TAC). At TAC, her primary focus is in assisting state and local organizations in the development of community support programs for adults with serious mental illness, special needs housing, development of business and organizational plans for managed care, workforce development and training, board training, and community development.

#### **Brian Lahren, Ph.D.**

Brian Lahren worked in the Nevada Division of Mental Health and Mental Retardation for 12 years, serving as commissioner from 1988 to 1992. He resigned from his position in protest over budget cuts which reduced community services and became Executive Director of the Washoe Arc. Since leaving state employment, Lahren has worked successfully to reestablish Nevada's community-based services, using statewide advocacy to ensure that the legislature restore the lost funding. Nevada now has the lowest rate of institutionalization in the United States for persons with mental retardation and developmental disabilities and is near the bottom in per capita institutionalization for individuals with mental illness.

#### **Brian R. Lensink**

Brian Lensink has managed developmental disabilities service systems in two states, Colorado and Connecticut. He has also provided consultation and support to the governments of Tennessee, Oklahoma, Kentucky, and Utah. As a consultant, Lensink has assisted states and counties with the development of community services and supports. He has published numerous articles and made many presentations on serving persons with developmental disabilities in integrated settings. Lensink continues to provide consultation services throughout the United States and in the Netherlands in a variety of areas, including institutional downsizing and closure strategies.

#### **John C. Lewin, M.D.**

From 1986 to 1994, John Lewin was Hawaii's Director of Health, overseeing 6,500 staff and a nearly \$1 billion annual budget. His responsibilities included Chief Executive Officer (CEO) and Director of the state Mental Health System, including comprehensive inpatient, outpatient, community, and preventive mental health; adolescent inpatient, outpatient, and community mental health; children's mental health services; and comprehensive substance abuse treatment and rehabilitation services. As Director of Behavioral Health Services, Lewin helped to deinstitutionalize the majority of patients at the old and unaccredited Hawaii State Mental Hospital, building a much smaller rehabilitation-oriented hospital with community-linked services, accreditation, and training programs for nurses, psychologists, and psychiatrists in partnership with the University of Hawaii. Lewin is Executive Vice President and CEO of the 35,000-member California Medical Association.

#### **David E. Loberg, Ph.D.**

David Loberg was appointed Director of the California Department of Developmental Services in 1978. During his five-year tenure, he oversaw a \$600 million budget and 18,000 employees in the provision of needed services for individuals with developmental disabilities. Since 1986, he has worked as a principal consultant with Dataserve, providing management consultation, psychological services, and data analysis services to a variety of health facilities, residential facilities, and human service programs in the North Bay and East Bay areas. Loberg is also a lecturer in psychology at Napa Valley College.

#### **Danna Mauch, Ph.D.**

Danna Mauch served as Director of Mental Health for the State of Rhode Island, Assistant Commissioner of Mental Health for Massachusetts and Executive Director of an ambulatory and long-term care provider. In the Commonwealth of Massachusetts, she directed the Divisions of Forensic Medicine, Mental Health



and Substance Abuse. Until recently, she served as the Special Master for the United States District Court for the District of Columbia, evaluating the implementation of reforms to the publicly-financed mental health system in the nation's capital. In her government roles, Mauch effected major systems changes in the provision of psychiatric care. As a result, Rhode Island's Mental Health System was rated number one in the nation by the Public Citizen Health Research Group.

Mauch served as member of the National Advisory Board of the U.S. Center for Mental Health Services and co-chaired a health care reform task force on behavioral health for the Labor and Human Resources Committee of the U.S. Senate. She was also Principal Investigator on a number of federal and foundation-funded research and demonstration projects in the mental health and long-term care fields. She has published several key articles and book chapters on the management of care and public/private partnerships in service delivery and systems management for the behavioral health care industry. Mauch is currently the Chief Executive Officer of Magellan Public Solutions, Inc., a health care organization with the capacity to deliver specialty care management solutions to the public sector.

#### **Neil Meisler**

Neil Meisler directed the Rhode Island Division of Mental Health from 1980 to 1984. He left the position to become the Director of Public Mental Health Services at the Southern Illinois University School of Medicine. At the university, Meisler implemented a public sector psychiatric residency rotation through affiliation of the Department of Psychiatry with a state hospital and a community mental health center. He also developed and directed a model program of assertive community treatment for persons with severe psychiatric disabilities. In 1986, Meisler became responsible for the day-to-day operations of the South Carolina Department of Mental Health, and from 1988 to 1993 he served as state commissioner for mental health in Delaware. Meisler is Assistant Professor of Psychiatry and Administrative Director of the Division of Public Psychiatry at the Medical University of South Carolina.

#### **Ronald Melzer, Ph.D.**

Ronald Melzer has 20 years of senior level management experience in the provision of mental health and developmental disabilities services. Melzer served 13 years in Vermont state government, including two years as the Director of Mental Retardation Programs. In Vermont he developed a comprehensive plan for replacing the state's institutions with an integrated network of community-based services and obtained a federal Medicaid waiver that enabled funding to follow clients. From 1987 to 1989, Melzer was the Deputy Director of Community Services for the New Jersey Division of Developmental Disabilities, and from 1989 to 1995, he oversaw quality assurance for mental health programs in the city of New York. From 1995 to 1998, as Vice President for Public Sector Program Development at Merit Behavioral Care Corporation, Melzer designed and implemented cost-effective, community-based alternatives to institutional programs.

#### **Marvin L. Meyers**

Marvin Meyers became Commissioner for Mental Retardation for Northeastern Pennsylvania in 1978. He came to Pennsylvania from Colorado where he served as State Director of Mental Retardation for the Colorado Department of Institutions for more than five years. In Colorado, he also held other positions such as State Director of Community Services for Institutions and State Supervisor of Programs for the Mentally Retarded for the State Department of Education.

During Meyers' tenure with the Department of Institutions, he reduced the institutional population by 25% in a five-year period while the state experienced growth of 11%, promoted institutional reforms and deinstitutionalization, and helped to establish 110 agencies in the community to provide residential and day services for people with mental retardation of all ages. He also served as a consultant to public and private non-profit agencies throughout the west and mid-west in matters relating to program development, administration and management. He initiated Colorado's first

comprehensive community-centered program for the individuals with mental retardation.

#### **Karen L. Middendorf**

Karen Middendorf served for two and one half years, from 1995 to 1997, as Director of the Division of Mental Retardation in the Kentucky Department for Mental Health and Mental Retardation Services. Her 28 years in the field of mental retardation-developmental disabilities services has included 13 years as the Mental Retardation/Developmental Disabilities Director for Comprehend Inc., the Regional Mental Health-Mental Retardation Board in Maysville, KY and 13 years in a variety of positions at the Human Development Institute-University Affiliated Program at the University of Kentucky, including Director of Outreach Services and Associate Executive Director. In these various positions Middendorf developed community services and supports for individuals with disabilities and their families; provided training and technical assistance to agency personnel at local, state and national levels, developed and taught interdisciplinary courses at the graduate and undergraduate level; promoted interagency coordination and collaboration; and both advocated for and developed public policy that supports choice and inclusion for all citizens.

Middendorf is a Fellow of the American Association on Mental Retardation and served as President of the National Association in 1995, as well as holding numerous other leadership positions in the state, regional, and national levels of the organization. She has served on numerous boards and task forces at state, regional, and national levels and been honored by a number of associations for her contributions to the positive change in services and supports for individuals with disabilities over the last 20 years.

#### **Dennis F. Mohatt**

Dennis Mohatt is the former Deputy Director of the Nebraska Department of Health and Human Services and the state's designated mental health commissioner. He was also the Executive Director of the Menominee County Community Mental Health Clinic

in Michigan. During his tenure in the rural upper-peninsula of Michigan, Mohatt developed high intensity and high quality community-based programming for persons with developmental disabilities and mental illnesses. These programs, ranging from ICF/MR services to Assertive Community Treatment (ACT) teams, were developed through the utilization of the same funds formerly expended exclusively for institutional care. In the 18 months prior to participating in the ACT program, a sample group of 32 persons with severe and persistent mental illness used over 3,000 days of inpatient services at an average cost of \$400 per day. In the 18 months following their enrollment in the ACT program, this same group used fewer than 300 days of inpatient care. The daily cost of ACT was \$100 per person, a system savings of approximately \$300 per person per day. The saved funds were then available to expand services for other area residents.

#### **John A. Morris**

John Morris served an interim appointment as Director of Mental Health for South Carolina from 1995 to 1997; he also served as Deputy State Director. Before 1990, he held numerous clinical and administrative positions in the Department of Mental Health, having begun his career as a ward attendant at the South Carolina State Hospital in 1969 and become a program director for the Missouri Department of Mental Health in the mid-1970's.

Morris currently holds a dual appointment as Professor of Neuropsychiatry and Behavioral Sciences at the University of South Carolina (USC) School of Medicine, and Director of Interdisciplinary Studies in the South Carolina Department of Mental Health's Division of Education, Training and Research. He is a member of the Affiliate Faculty of the Institute for Families in Society at USC and Adjunct Professor in the USC School of Social Work, where he lectures on health and mental health policy. Principal Investigator on a federally funded grant to build consensus for the statewide replication of a rural assertive community treatment model, he also serves as Project Co-Director and Moderator of TeleConsultations, an interactive teleconference series on mental health issues that is broadcast statewide. A frequent guest lecturer in both university settings and at state and national meetings,



he is the author or co-author of a number of journal articles and book chapters on mental health policy issues.

#### **Charles Moseley, Ed.D.**

For 11 years, Charles Moseley was the Director of the Vermont Division of Developmental Services, where he led the efforts to close the state's institution, transition all services to individuals with developmental disabilities to individualized community based alternatives, and more recently, to restructure the service delivery system to institute principles of managed care and self-directed services. He holds a doctorate in special education, mental retardation policy, from Syracuse University and has consulted with several states and organizations on the development of community services for people diagnosed as having mental retardation or developmental disabilities. Moseley is the Co-Director of the Robert Wood Johnson Foundation's Self Determination Project and the Associate Director of the Institute on Disability at the University of New Hampshire.

#### **Frank M. Ochberg, M.D.**

Frank Ochberg was Director of the Michigan Department of Mental Health from 1979 to 1981. Prior to serving in that position, he spent seven years at the National Institute of Mental Health (NIMH), the last two as Associate Director. He has published over 100 titles, many on community mental health services, in scientific and lay publications and has served as a consultant to the Federal Bureau of Investigation, the U.S. Secret Service, and the London Metropolitan Police (Scotland Yard). At Michigan State University, he is a Clinical Professor of Psychiatry, an Adjunct Professor of Criminal Justice, and an Adjunct Professor of Journalism. Ochberg is a psychiatrist in private practice in Michigan.

#### **Robert L. Okin, MD**

Robert Okin is the former Commissioner of Mental Health for both the state of Vermont and the state of Massachusetts. He is a consultant with Mental Disabilities Rights International and is a

nationally and internationally known expert on human rights for people with mental disabilities.

As Chief of Service of the San Francisco General Hospital (SFGH) Department of Psychiatry, Professor of Clinical Psychiatry, and Vice Chair of the University of California at San Francisco (UCSF) School of Medicine's Department of Psychiatry, Okin's major role is to provide leadership to and administration of the SFGH site of the UCSF Department of Psychiatry. Since he joined the Department in 1990, his major effort has been focused in the development and expansion of both mental health/substance abuse services and the academic mission at this site. He has overseen the development of crucial services for San Francisco's most critically mentally ill, including the SFGH Department of Psychiatry's Case Management Program for High Users of the Emergency Department which received this year's National Association of Public Hospital's Safety Net Award, the Crisis Resolution Team for psychiatric patients in crisis, a Partial Hospitalization Program for patients transitioning from acute inpatient care, a variety of outpatient and inpatient Substance Abuse Programs, the establishment of the Division of Psychosocial Medicine, and the Department of Public Health's capitate contract for comprehensive mental health services for 200 of San Francisco's most expensive users of the mental health system.

#### **Mike Pedneau**

As the North Carolina State Director of Mental Health, Developmental Disabilities and Substance Abuse, Mike Pedneau brought federal class action lawsuits to closure by complying with the settlement agreement in *Willie M. v. Hunt* and by achieving compliance in the Court Order in *Thomas S. v. Hunt*. The latter case involved a class of 2,000 people with mental retardation who spent more than 30 days in state psychiatric hospitals. By treating and habilitating people with mental retardation in community settings, North Carolina was able to continue downsizing its state hospitals and shift nearly 60% of the cost of this care to federal Medicaid funds. Since compliance, North Carolina has continued to divert people with mental retardation from care in state hospitals unless extreme circumstances are involved. During Pedneau's

six years as the State Director, the federal mental retardation/developmental disabilities waiver was expanded and slots under the waiver were expanded dramatically in exchange for decreasing the state's institutional beds by 4% per year.

#### **Peter P. Polloni**

Peter Polloni was Executive Director of the Pennsylvania Arc from 1971 to 1977, a time of great change for persons with developmental disabilities as the trend shifted from institutional care to community integration. After the Arc, he served for two years as the director of the Pennsylvania Office of Mental Retardation before becoming the Deputy Director for the Ohio Department of Mental Retardation/Developmental Disabilities. In northeast Ohio, he oversaw the downsizing of two institutions and the enlargement of community alternatives. Polloni left state government to spend 14 years with Mentor, a company that has been a leader in the development of community-based services for persons with severe disabilities.

#### **R. Emmett Poundstone, III**

Emmett Poundstone served as Commissioner of the Alabama Department of Mental Health and Mental Retardation on two separate occasions, from 1985 to 1986 and from 1995 to 1996. In addition to serving as Commissioner, he has held several other positions within the Alabama Department of Mental Health and Mental Retardation during his nearly 23 years of employment. Positions held include Chief Council from 1979 to 1981, Director of the Division of Legal and Administrative Services from 1981 to 1984 and Associate Commissioner for Mental Illness from 1988 to 1995. He retired in 1997 as the Deputy Commissioner.

#### **Toni Richardson**

Toni Richardson served as Commissioner of the Connecticut Department of Mental Retardation from January 1990 to January 1995, a period marked by the development of community-based alternatives to replace institutional facilities and an emphasis on

the development of high quality community services. During part of that time, Richardson served on the Board of Directors of the National Association of State Developmental Disability Directors.

#### **Thomas D. Romeo**

Thomas Romeo was Director of Rhode Island's statewide agency for mental health for 12 years. With the support of four Governors, the Rhode Island State Legislature, and many citizens, he established a system of services based upon individual needs and ultimate return to one's home community. In Rhode Island, institutional settings continue to be considered a "last resort."

#### **Kingsley R. Ross**

Kingsley Ross served as Florida's Assistant Secretary for Developmental Services from 1987 to 1992. During his tenure, he directed a statewide agency with over 5,000 employees and a budget in excess of \$500 million; approved policy, plans, budgets, and procedures; proposed and lobbied for legislation; advised and consulted local, state, and federal officials as well as constituency groups. Ross' accomplishments included the following: creating and implementing an integrated organization-wide fiscal and customer information system, linking budgets and expenditures to consumer demand for services for person with developmental disabilities; increasing revenues by \$16.5 million in 6-month period; creating and implementing fee-based cost reimbursement systems; developing systems for evaluating the service quality at the national, regional, and individual consumer level; providing national and international consultation to a variety of private and public organizations serving persons with developmental disabilities on topics ranging from contract negotiations to management and budget control systems. From 1983 to 1987, Ross was Executive Director of the Florida chapter of the Arc. He currently works as the President of Minuteman Systems, Inc.



### **Lyn Rucker**

Lyn Rucker has over 25 years experience in the planning, development, administration, quality enhancement, and financing of institutional and community support systems for people with a variety of needs in the United States and, for the past 12 years, in the United Kingdom as well. She has extensive experience in the evaluation and review of developmental disabilities and mental health supports and services, in-patient psychiatric hospitals, natural supports and community services, and services offered in forensic units. From 1987 to 1991, Rucker oversaw the Division of Developmental Disabilities for the state of Arizona. In that position, she was responsible for designing and directing the first managed care system for people with developmental disabilities in the United States. Ninety-six percent of the children and adults receiving health, medical, and individualized supports and services did so in the community. During her four years as state director in Arizona, the state closed an institution in Phoenix and downsized by half their facility in Tucson. One private ICF/MR was also closed.

### **Jerry L. Schrader, M.D.**

Jerry Schrader was the Director of Mental Health and Developmental Disabilities for the State of Alaska from 1973 to 1978. The following two years he spent as the Chief of Planning and Technical Assistance in the Bay Area Regional Office of the Department of Mental Health of the State of California. As the Chief, Schrader was the second highest ranking official in the regional office, representing the Department in providing state approval and oversight to the five counties surrounding San Francisco Bay. Schrader is a Fellow of the American Psychiatric Association.

### **Walter W. Shervington, M.D.**

From 1992 to 1996, Walter Shervington served as the Assistant Secretary of the Office of Mental Health, the mental health authority for the state of Louisiana. Among his duties were the operations of six state-run psychiatric hospitals, including a foren-

sic hospital, and 46 state-run community mental health centers or clinics; innovating, developing, and monitoring new services as the needs demand; and overseeing the expenditure of more than \$20 million in federal grant funds. Prior to his appointment as Assistant Secretary, Shervington was an Associate Professor of Psychiatry with tenure at the Louisiana State University School of Medicine. Early in his career, he spent four years as Chief of the Psychiatry Training Branch of the National Institutes of Mental Health. Shervington is a member of the U.S. Department of Health and Human Services, Health Resources and Services Administration, National HIV/AIDS Advisory Committee and is a psychiatrist in private practice.

### **Edward Russell Skarnulis, Ph.D.**

From 1985 to 1990, Edward Skarnulis served as the Director of Minnesota's Division for Persons with Developmental Disabilities. Prior to his tenure in Minnesota, he managed statewide programs in Texas and Kentucky. In 1990, Skarnulis was appointed as one of three members of a review panel created under the terms of a consent decree in *Homeward Bound v. Hissom Memorial Center*, in the United States District Court for the Northern District of Oklahoma. The panel worked with staff to oversee the court-ordered closing of an 850-bed state institution for person with mental retardation. Skarnulis is a member of the National Advisory Board of the Research and Training Center on Community Integration at Syracuse University and a consulting editor for *Mental Retardation*, the journal of the American Association on Mental Retardation.

### **Thomas Sullivan**

Thomas Sullivan has worked in state government for 32 years in three different states: Connecticut, Florida and, most recently, Tennessee where he served as State Director for the past two and a half years until resigning at the end of January. Sullivan entered the field in 1967 as a direct care worker in a state facility in Connecticut, launching a career that would involve a number of "hands on" and administrative positions in facilities and commu-

nity programs. For the past 21 years, all of his experience has been in community-based services. Sullivan has been involved, along with a number of other people, in the closing of three residential facilities: the Mansfield Training School and Seaside Regional Center in Connecticut and Nat. T. Winston Developmental Center in Tennessee.

#### **Richard C. Surles**

Richard Surles has more than two decades of experience in health planning and programming. Previously, he was a commissioner of mental health for the states of New York and Vermont, an administrator for the Office of Mental Health and Mental Retardation for the City and County of Philadelphia, an assistant director of the North Carolina Division of Mental Health and Mental Retardation, and a member of the Mental Health Study Commission for the North Carolina State Legislature. Surles also was vice president for national operations and Chief Executive Officer of Public Sector Services at Merit Behavioral Care.

In addition, Surles has taught and held positions as co-director of the Post-Doctoral Program in Mental Health Evaluation at the School of Public Health and associate director for the Developmental Disabilities Technical Assistance System at the Frank Porter Graham Child Development Center of the University of North Carolina at Chapel Hill. He has served on numerous national advisory committees on mental health and health care policy, and has published more than 30 articles in industry journals. He is as an honorary fellow of the American Psychiatric Association and has received several career recognition awards from the National Alliance for the Mentally Ill, the National Mental Health Association and the National Association of State Mental Health Directors.

#### **Henry Tomes, Ph.D.**

From 1989 to 1991, Henry Tomes was the Commissioner of Mental Health for the state of Massachusetts, after having served as deputy commissioner for several years. In both positions, he expanded community mental health programs, by increasing placements of persons with mental illness in community resi-

dences, providing for significant expansion of psychosocial rehabilitation programs, and beginning the process of closing and/or downsizing the Commonwealth's mental health hospitals. Tomes is currently employed as Executive Director, Public Interest, American Psychological Association from 1991. His Public Interest Directorate supports policy and administrative activities associated with issues involving gender, age, sexual orientation, disabilities, ethnic minorities, AIDS and urban affairs.

#### **Harold M. Visotsky, M.D.**

Harold Visotsky's career in mental health has spanned more than 40 years. After four years as Director of Mental Health for Chicago, Visotsky served six years as Director of the Illinois state mental health system. Visotsky has accumulated numerous awards for his work in the U.S. and abroad, including the Presidential Award for Contributions to Hospital Psychiatry by the American Association of General Hospital Psychiatrists and two Gold Medals for Contributions to the Field of Psychiatry from the American College of Psychiatrists. He has provided consultation on mental health care to the governments of Japan, Italy, and the former U.S.S.R. and was Chair of a U.S. State Department/National Institute of Mental Health Team on an official visit to investigate possible human rights violations in psychiatric hospitals of the former U.S.S.R.

Visotsky is the Owen L. Coon Professor of the Department of Psychiatry and Behavioral Sciences at Northwestern University Medical School. He also serves as a Senior Consultant to the Center for Mental Health and Psychiatry Services of the American Hospital Association, an organization he directed from 1979 to 1985.

#### **Gary K. Weeks**

##### **Director, Oregon Department of Human Resources**

Gary Weeks is the current Director of the Oregon Department of Human Resources, the state's health and human services agency. In addition to overseeing the Mental Health and Developmental Disability Services Division, Weeks directs the work of



the Adult and Family Services Division, Health Division, Senior and Disabled Services Division, State Office for Services to Children and Families, Vocational Rehabilitation Division, Office of Alcohol and Drug Abuse Programs, and the Office of Medical Assistance Programs (Medicaid). The department has a staff of 9,650 and a 1997-99 biennial budget of \$6 billion. Weeks is signing on in his official capacity.

#### **Ric Zaharia, Ph.D., FAAMR**

Ric Zaharia served as Director of the Utah Division of Services to People with Disabilities from 1990-1995. During his tenure, deinstitutionalization processes were established to implement state statutes requiring services in the least restrictive environment. Utah's Home and Community Based Services waiver and state budgeting processes were revised to expand community capacity and permit the routine movement of institutional monies behind individuals for whom treatment teams recommended community placement. During this period, approximately 150 of the 450 residents of the state's one institution were successfully moved into community settings. In addition, diversion efforts were established to redirect unnecessary institutional admissions to community placements. These efforts continue today.

Zaharia has also been involved in efforts in Colorado and North Carolina to accomplish the same state policies relative to placement in the least restrictive, most integrated settings. In Colorado as the DD Division's Director of Behavioral Services, he directed the implementation of supports to relocate approximately 100 individuals with dual diagnoses out of the Colorado State Hospital and Wheat Ridge Regional Center. In North Carolina as a facility director, he devised institutional funding transfers to support the movement of approximately 400 people out of the Caswell Center and into more appropriate community settings based on the recommendations of treatment teams.

#### **George A. Zitnay, Ph.D.**

While Assistant Commissioner for Mental Retardation for Massachusetts, George Zitnay managed the administration of a

comprehensive statewide service delivery system for persons with mental retardation, autism, and traumatic brain injury. He left state government to become Executive Director of the Joseph P. Kennedy, Jr. Foundation, where his accomplishments included directing special projects on ethics and training of mental retardation professionals and teaching at Georgetown University.

From 1990 to 1998, Zitnay served as President of the Brain Injury Association. He directed all activities of the Association, including training, research and prevention in brain injury. He has served on the National Institutes of Health Advisory Board for the National Institute on Child Health and Human Development, as Chair of the National Center on Medical Rehabilitation, and as Chair of the National Institute on Disability and Rehabilitation Research. Zitnay presently is a Professor and Director of Research and Training at the Virginia Neurological Institute, University of Virginia; Clinical Director of the John Jane Brain Injury Center; and President of the International Brain Injury Association.

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No. 98-536

In The  
**SUPREME COURT OF THE UNITED STATES**  
October Term, 1998

Tommy Olmstead, Commissioner, Georgia  
Department of Human Resources, et al.,  
*Petitioners,*  
v.

L.C., by Jonathan Zimring,  
Guardian Ad Litem and Next Friend, et al.,  
*Respondents.*

On Writ Of Certiorari  
To the United States Court of Appeals  
For The Eleventh Circuit

BRIEF OF AMICI CURIAE,  
AMERICAN CIVIL LIBERTIES UNION  
AND ACLU OF GEORGIA,  
IN SUPPORT OF RESPONDENTS

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## TABLE OF CONTENTS

|  | Page |
|--|------|
| TABLE OF CONTENTS .....  | i    |
| TABLE OF AUTHORITIES .....   | ii   |
| INTEREST OF THE AMICI CURIAE .....   | 1    |
| STATEMENT OF THE CASE .....  | 1    |
| SUMMARY OF THE ARGUMENT .....  | 3    |
| ARGUMENT .....   | 5    |
| I. UNDER OUR CIVIL RIGHTS LAWS AND<br>EQUAL PROTECTION JURISPRUDENCE,<br>THE UNJUSTIFIED SEGREGATION OF<br>MINORITY GROUPS THROUGH OFFICIAL<br>ACT OR DECREE IS AN IMPERMISSIBLE<br>FORM OF DISCRIMINATION. .... | 5    |
| II. CONGRESS ENACTED THE AMERICANS<br>WITH DISABILITIES ACT TO EXTEND<br>THE PROTECTIONS OF EXISTING CIVIL<br>RIGHTS LAW TO DISABLED<br>INDIVIDUALS .....  | 9    |
| III. THE AMERICANS WITH DISABILITIES<br>ACT PROHIBITS THE UNNECESSARY<br>SEGREGATION OF INDIVIDUALS WITH<br>MENTAL DISABILITIES .....  | 14   |
| CONCLUSION .....   | 19   |

## TABLE OF AUTHORITIES

## CASES

|   |             |
|---|-------------|
| <i>Briggs v. Elliott</i> ,<br>132 F. Supp. 776 (E.D.S.C. 1955) . . . . .                                | 6           |
| <i>Brown v. Board of Education</i> ,<br>347 U.S. 483 (1954) . . . . .                                   | 3, 5, 6, 11 |
| <i>Califano v. Webster</i> ,<br>430 U.S. 313 (1977) . . . . .   | 9           |
| <i>City of Cleburne, Tex. v. Cleburne Living Center</i> ,<br>473 U.S. 432 (1985) . . . . .              | 15, 16      |
| <i>Helen L. v. DiDario</i> ,<br>46 F.3d 325 (3d Cir. 1995) . . . . .                                    | 3, 11, 14   |
| <i>International Union, U.A.W. v. Johnson Controls, Inc.</i> ,<br>499 U.S. 187 (1991) . . . . .         | 18          |
| <i>J.E.B. v. Alabama ex rel. T.B.</i> ,<br>511 U.S. 127 (1994) . . . . .                                | 7, 8        |
| <i>Kelley v. The Altheimer, Ark. Pub. Sch. Dist. No. 22</i> ,<br>378 F.2d 483 (8th Cir. 1967) . . . . . | 6           |
| <i>L.C. v. Olmstead</i> ,<br>138 F.3d 893 (11th Cir. 1998) . . . . .                                    | passim      |
| <i>Levy v. Louisiana</i> ,<br>391 U.S. 68 (1968) . . . . .  | 9           |

|  |            |
|--|------------|
| <i>McKennon v. Nashville Banner Publ'g Co.</i> ,<br>513 U.S. 352 (1995) . . . . .                    | 11         |
| <i>O'Conner v. Donaldson</i> ,<br>422 U.S. 563 (1975) . . . . .                                      | 16         |
| <i>Pennhurst State Sch. &amp; Hosp. v. Halderman</i> ,<br>451 U.S. 1 (1981) . . . . .                | 13         |
| <i>Pennsylvania Dept. of Corrections v. Yeskey</i> ,<br>524 U.S. 206 (1998) . . . . .                | 17         |
| <i>United States v. Fordice</i> ,<br>505 U.S. 717 (1992) . . . . .                                   | 7          |
| <i>United States v. Jefferson County Board of<br/>Educ.</i> , 372 F.2d 836 (5th Cir. 1966) . . . . . | 6, 7       |
| <i>United States v. Virginia</i> ,<br>518 U.S. 515 (1996) . . . . .                                  | 3, 7, 8, 9 |

## STATUTES

|   |        |
|---|--------|
| Age Discrimination in Employment Act of 1967,<br>Pub. L. 90-202, 81 Stat. 602 . . . . . | 10     |
| Americans with Disabilities Act of 1990,<br>Pub. L. 101-336, 104 Stat. 327 . . . . .    | passim |
| Civil Rights Act of 1964,<br>Pub.L. 88-352, 78 Stat. 241 . . . . .                      | 10     |
| 42 U.S.C. § 2000a (1998) . . . . .  | 10     |
| 42 U.S.C. § 2000d (1998) . . . . .  | 10     |



|   |    |
|---|----|
| 42 U.S.C. § 2000e (1998) . . . . .  | 10 |
| Civil Rights Act of 1991,<br>Pub.L. 102-166, 105 Stat. 1071 . . . . .   | 10 |
| Developmentally Disabled Assistance and<br>Bill of Rights Act of 1975<br>Pub. L. 94-103, 89 Stat. 486 . . . . . | 13 |
| Education Amendments of 1972,<br>Pub.L. 92-318, 86 Stat. 375 . . . . .  | 10 |
| Rehabilitation Act of 1973,<br>Pub. L. 93-112, 87 Stat. 355 . . . . .   | 10 |

#### REGULATIONS

|                                |              |
|--------------------------------|--------------|
| 28 C.F.R. § 35.130 . . . . .   | 2, 4, 14, 17 |
| 28 C.F.R. § 41.51(d) . . . . . | 4, 14        |

#### LEGISLATIVE MATERIALS

|   |        |
|---|--------|
| 134 Cong. Rec. S5106, 5107-5108 (1988) . . . . .                          | 12     |
| 135 Cong. Rec. E2812, E2813 (1989) . . . . .                              | 12     |
| 136 Cong. Rec. H2421, H2428, H2438,<br>H2445, H2447-2448 (1990) . . . . . | 12, 13 |
| 136 Cong. Rec. H2599, H2616, H2639 (1990) . . . .                         | 13     |
| H.R. Rep. No. 101-485, pt. 3 at 26 (1990) . . . . .                       | 11     |

|   |    |
|---|----|
| <i>Hearings on S. 933 Before the Senate Comm. on<br/>Labor and Human Resources and the Subcomm. on<br/>the Handicapped, 101st Cong. 215 (1989).</i> . . . . . | 12 |
|---|----|

#### OTHER AUTHORITIES

|  |    |
|--|----|
| Timothy M. Cook, <i>The Americans With Disabilities<br/>Act: The Move to Integration</i> , 64 Temp. L.<br>Rev. 393, 409-410 (1991) . . . . .   | 16 |
| Chai Feldblum, <i>Antidiscrimination Requirements<br/>of the ADA In Implementing the Americans with<br/>Disabilities Act</i> (Lawrence O. Gostin & Henry<br>A. Beyer, eds. 1992) . . . . . | 17 |
| Edward J. Larson, <i>Sex, Race and Science</i> (1995) . .  | 16 |

## INTEREST OF THE AMICI CURIAE

The American Civil Liberties Union (ACLU) is a nationwide, nonprofit, nonpartisan organization with nearly 300,000 members dedicated to preserving the principles of liberty and equality that are embodied in the Constitution and our nation's civil rights laws. The ACLU of Georgia is one of its statewide affiliates.

ACLU affiliates around the country have been intensely engaged for nearly three decades in the effort to end the unnecessary segregation of the mentally disabled, beginning with the work of our New York affiliate on behalf of Willowbrook residents in the early 1970's, and continuing to this day. On a federal level, the ACLU was deeply involved in the advocacy effort that ultimately led to the enactment of the Americans with Disabilities Act (ADA). Both in disability cases and otherwise, the ACLU has appeared before this Court on numerous occasions as direct counsel and as amicus curiae.<sup>1</sup>

## STATEMENT OF THE CASE

L.C. and E.W. are mildly retarded adults who have been diagnosed with additional mental disorders. At the commencement of this litigation, they were confined in a locked ward of a psychiatric hospital run by the State of

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<sup>1</sup> Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3. Pursuant to Rule 37.6, counsel for amici states that no counsel for a party authored the brief in whole or in part and no person or entity, other than the amici curiae and its counsel, made a monetary contribution to the preparation or submission of the brief.



Georgia. *See L.C. v. Olmstead*, 138 F.3d 893, 895 (11th Cir. 1998).

L.C. initiated this action, challenging the State's failure to provide her with care in the most integrated setting appropriate to her needs. *See id.* The complaint sought a declaratory judgment holding that her institutionalization violated the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12131-12134, the Attorney General's Title II regulations, 28 C.F.R. § 35.130 (1997), and the Due Process Clause of the Fourteenth Amendment. *See id.* She also sought an injunction requiring the State to place her in a community-based treatment program. E.W. later intervened, asserting identical claims. *See id.*

Noting that the State had conceded that L.C. and E.W. qualified for community-based programs, the district court granted the requested relief. *See L.C. v. Olmstead*, No. 1:95-CV-1210-MHS, 1997 WL 148674, at \*3-4 (N.D. Ga. 1997). The United States Court of Appeals for the Eleventh Circuit affirmed the ruling that the ADA imposed on the State a general duty to administer services to the plaintiffs in the most integrated setting appropriate to their needs. *See L.C. v. Olmstead*, 138 F.3d at 902. The court remanded, however, instructing the district court to assess whether its ruling would impose such a great burden on the State's mental health budget as to fundamentally alter the services provided. *See id.* at 905.

The State has argued throughout these proceedings that it is not required by the ADA to provide "the least restrictive treatment" to individuals with psychiatric disabilities. It argues further that, in light of the financial burdens allegedly associated with integration, a state's decision to provide or deny a community-based program should be immune from

review under the ADA. In rejecting the State's argument, the Court of Appeals found that "[b]y definition, where, as here, the State confines an individual with a disability in an institutionalized setting when community placement is appropriate, the State has violated the core principles underlying the ADA's integration mandate." *Id.* at 897. The court based this conclusion on the ADA's legislative history, the plain language of the Act, its implementing regulations, and the analysis of the ADA set out in *Helen L. v. DiDario*, 46 F.3d 325, 331-32 (3d Cir. 1995).

### SUMMARY OF THE ARGUMENT

The Court should affirm the judgment below because the unnecessary segregation of mentally disabled individuals who are appropriate for community placement violates some of the most fundamental civil rights guaranteed to American citizens, as well as the express judgment by Congress to extend those rights to the disabled through the ADA.

I. Forty-five years ago this Court ruled that racial segregation violates the equal protection clause of the Fourteenth Amendment. Such segregation is inherently discriminatory because of its damaging effects on the excluded individuals. It sends a message of inferiority and perpetuates stereotypes with their resulting stigma. *See Brown v. Board of Educ.*, 347 U.S. 483, 494 (1954). The Court also has condemned exclusionary practices directed at women. "[Gender] classifications may not be used, as they once were, . . . to create or perpetuate the legal, social, and economic inferiority of women." *United States v. Virginia*, 518 U.S. 515, 534 (1996). The fundamental civil rights prohibition against unnecessary segregation applies in the disability context for the same reasons.

II. Congress enacted the Americans with Disabilities Act against the backdrop of our nation's other civil rights laws and with the express purpose of providing disabled individuals with equivalent protection against discrimination. Comparing disability discrimination to race and gender discrimination, senators and representatives denounced the segregation of disabled Americans in the ADA hearings and committee reports and explained that the ADA promises a future of integration for these individuals.

The ADA itself makes it clear that Congress did not pass this law merely to express an hortatory preference for integration. Rather, the Act sets forth a comprehensive mandate, specifically aimed at redressing discrimination against individuals with disabilities resulting from unnecessary institutionalization and segregation. *See* 42 U.S.C. § 12101 (1998). Further, in passing the ADA, Congress instructed the Attorney General to promulgate regulations consistent with the coordination regulations issued under section 504 of the Rehabilitation Act--which in turn mandate that recipients of federal financial assistance administer programs "in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 C.F.R. § 41.51(d) (1998); 42 U.S.C. § 12134(b). The Attorney General complied with the Congressional directive by including an express integration mandate in the ADA's implementing regulations. *See* 28 C.F.R. Part 35, App. A. § 35.130 (1999).

III. Even though mentally disabled Americans have been subjected to segregation that parallels the historic patterns of racial discrimination, Petitioners now ask this Court to endorse the outdated "separate but equal" concept with respect to mentally disabled individuals qualified for community placement. The Court should reject Petitioners'

request because: (1) the plain language of the ADA integration mandate covers Americans with mental disabilities; (2) the unnecessary segregation of mentally disabled individuals is inherently discriminatory; (3) the Petitioners' segregationist practices cannot be excused by paternalistic or other "benign" motives that perpetuate the stigma resulting from unnecessary institutionalization; and (4) Petitioners' concerns regarding the practicalities of a mass deinstitutionalization do not justify the unnecessary segregation of those individuals who, like L.C. and E.W., are qualified for community placement.

## ARGUMENT

### I. UNDER OUR CIVIL RIGHTS LAWS AND EQUAL PROTECTION JURISPRUDENCE, THE UNJUSTIFIED SEGREGATION OF MINORITY GROUPS THROUGH OFFICIAL ACT OR DECREE IS AN IMPERMISSIBLE FORM OF DISCRIMINATION

The unnecessary segregation of mentally disabled individuals violates some of the most fundamental civil rights principles guaranteed to American citizens.

The inextricable link between segregation and discrimination was permanently etched into our social and constitutional consciousness by this Court's landmark decision, forty-five years ago, in *Brown v. Board of Education*, 347 U.S. 483 (1954). Although the Court was writing then in the context of racial discrimination, its views on the meaning of equality have had a broader resonance both in this Court's own cases and in the civil rights laws that Congress has enacted in the intervening years. As the



*Brown* Court explained in rejecting the doctrine of "separate but equal," government-imposed segregation is inherently discriminatory because it sends a message of inequality that carries lifelong consequences for both the majority and the minority that cannot be erased merely by equal programs and facilities.

Our decision, therefore, cannot turn on merely a comparison of these tangible factors . . . We must look instead to the effect of segregation itself . . .

[To segregate children] generates a feeling of inferiority as to their status in the community that may affect their hearts and minds in a way unlikely ever to be undone. . . .

Separate educational facilities are inherently unequal.

*Id.* at 492, 494-495.

After this Court's ruling in *Brown v. Board of Education*, one of the lower courts embraced an argument on remand that resembles the position of the petitioners here--that the law "does not require integration. It merely forbids discrimination." *Briggs v. Elliott*, 132 F. Supp. 776, 777 (E.D.S.C. 1955). Eventually, however, the appellate courts extinguished this notion as logically inconsistent with *Brown*. See, e.g. *Kelley v. The Altheimer, Ark. Pub. Sch. Dist. No. 22*, 378 F.2d 483, 488 (8th Cir. 1967). As noted by the Fifth Circuit, this attempt to avoid integration in fact perpetuated racial segregation, with all of its deleterious effects, for more than a decade after *Brown*. See *United*

*States v. Jefferson County Bd. of Educ.*, 372 F.2d 836, 862-863, 866 (5th Cir. 1966).

More broadly, the Fifth Circuit recognized that a failure to pursue integration following a state-sanctioned policy of segregation is "per se discriminatory." *Id.* at 872. "Denial of access to the dominant culture, lack of opportunity in any meaningful way to participate in political and other public activities, the stigma of apartheid . . . are concomitants of the dual educational system." *Id.* at 866. This Court later confirmed that "a State does not discharge its constitutional obligations until it eradicates policies and practices traceable to its prior de jure dual system that continue to foster segregation." *United States v. Fordice*, 505 U.S. 717, 727 (1992). In other words, a neutral policy is not sufficient where there are continuing effects of state-imposed segregation. See *id.* at 731-732. In such a case, there is an affirmative duty to desegregate, and the maintenance of separate institutions violates the Fourteenth Amendment. See *id.* at 727-733.

Recently, this Court applied these principles to compel the integration of the Virginia Military Institute (VMI) in *United States v. Virginia*, 518 U.S. 515 (1996). That the VMI case involved gender integration rather than racial integration did not fundamentally change the equal protection analysis. In holding that VMI can not exclude a female applicant on the basis of her gender if her admission is otherwise appropriate, the Court rejected VMI's defense that it offered women a separate but equal program at Mary Baldwin College. See *id.* at 526-527, 534.

The integration of VMI was based in part on the "core instruction" of *J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127 (1994), cited in *United States v. Virginia*, 518 U.S. at 531.

The *J.E.B.* Court explained that the discriminatory effects inherent in segregation are not confined to the context of racial discrimination.

While the prejudicial attitudes toward women in this country have not been identical to those held toward racial minorities, the similarities between the experiences of racial minorities and women, in some contexts, "overpower those differences." . . . Certainly, with respect to jury service, African-Americans and women share a history of total exclusion. . . .

The message it sends . . . is that certain individuals, for no reason other than gender, are presumed unqualified. . . .

*J.E.B.*, 511 U.S. at 135, 142 (citation omitted). VMI's admission policy, therefore, was illegal because it perpetuated "the legal, social, and economic inferiority of women" based on stereotypes and myths. See *United States v. Virginia*, 518 U.S. at 533-534.

Further, the State's benign explanations for the segregation did not excuse the discrimination. See *id.* at 535-538. The State advanced the argument, among others, that "[m]ales tend to need an atmosphere of adversativeness," while "[f]emales tend to thrive in a cooperative atmosphere." *Id.* at 541. In striking down VMI's policy, the court acknowledged that the rigors of VMI's program might pose problems for many women. See *id.* at 533, 541. Nonetheless, VMI's segregationist policy was illegal because it unnecessarily excluded even those individuals who were appropriate for placement in its program. See *id.* at 542, 557. Simply put, "state actors

may not rely on 'overbroad' generalizations to make judgments about people that are likely to . . . perpetuate historical patterns of discrimination.'" *Id.* at 542.<sup>2</sup> Accord *Califano v. Webster*, 430 U.S. 313, 318 (1977) (gender discrimination cannot be justified by relying on "archaic and overbroad generalizations" about women), citing *Schlesinger v. Ballard*, 419 U.S. 498, 508 (1975). See also *Levy v. Louisiana*, 391 U.S. 68 (1968) (equal protection clause does not permit discrimination against illegitimate children based on outmoded stereotypes).

These same fundamental civil rights principles apply with equal force in the context of disabled individuals.

## II. CONGRESS ENACTED THE AMERICANS WITH DISABILITIES ACT TO EXTEND THE PROTECTIONS OF EXISTING CIVIL RIGHTS LAW TO DISABLED INDIVIDUALS

The Americans with Disabilities Act was not created out of whole cloth. Rather, Congress enacted it against the backdrop of our nation's other civil rights laws and the equal protection clause of the Fourteenth Amendment. Congress designed the ADA to extend to disabled individuals the same

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<sup>2</sup> The Court also rejected Virginia's argument that the exclusion of women from VMI promoted diversity through single-sex educational options. See *United States v. Virginia*, 518 U.S. at 536. After analyzing the history of higher education in Virginia, the Court concluded that the VMI policy did not arise from an effort to diversify but rather was deeply rooted in a history of discrimination against women. See *id.* at 536-540. The history of society's segregation of mentally disabled individuals leads to the conclusion that Georgia's "benign" explanations here similarly seek to mask discrimination. See, *infra*, Part III.



protection against discrimination provided by existing law to racial minorities and women.

The Civil Rights Act of 1964, Pub.L. 88-352, 78 Stat. 241, established the basic statutory framework. Title II of the Act (codified at 42 U.S.C. § 2000a (1998)), bars discrimination in places of public accommodation on the basis of race, religion, color, or national origin. Title VI (codified at 42 U.S.C. § 2000d (1998)), bars discrimination on the basis of race, color, or national origin by recipients of federal funds. Title VII (codified at 42 U.S.C. § 2000e (1998)), prohibits employment discrimination against women as well as racial and ethnic minorities.

Building on this model, Congress has enacted since 1964 a succession of statutes designed to expand and strengthen our nation's commitment to equal rights in three principal ways. First, Congress has extended the reach of the civil rights laws to new contexts. *See, e.g.*, Title IX of The Education Amendments of 1972, Pub. L. No. 92-318, 86 Stat. 375 (codified at 20 U.S.C. §§ 1681-1683(1998)) (generally prohibiting educational discrimination on the basis of gender). Second, Congress has enhanced the remedies available to victims of discrimination. *See, e.g.*, The Civil Rights Act of 1991, Pub. L. No. 102-166, 105 Stat. 1071 (authorizing compensatory and punitive damages for certain Title VII violations). Third, and most relevant to this case, Congress has broadened the scope of the civil rights laws to reach previously unprotected groups. *See, e.g.*, The Rehabilitation Act of 1973, Pub. L. 93-112, 87 Stat. 355 (codified at 29 U.S.C. § 794 (1998)) (barring discrimination against any otherwise qualified handicapped individual in federally funded programs); The Age Discrimination in Employment Act of 1967, Pub. L. 90-202, 81 Stat. 602 (codified at 29 U.S.C. §§ 621-634 (1998)).

When the ADA was enacted, these other civil rights laws served as both history and model. *See McKennon v. Nashville Banner Publ'g Co.*, 513 U.S. 352, 357 (1995) (recognizing that the ADA is part of a wider statutory scheme aimed at the elimination of invidious bias); *Helen L. v. DiDario*, 46 F.3d 325, 331 (3rd Cir. 1995) (finding that the ADA was Congress' response to the need for "civil rights" legislation for the disabled).

The ADA's legislative history establishes that Congress intended the ADA to place disability discrimination on a par with race and gender discrimination and, specifically, to end the discriminatory effects of the historic segregation of disabled Americans.

The Americans With Disabilities Act completes the circle begun in 1973 with respect to persons with disabilities by extending to them the same civil rights protections provided to women and minorities beginning in 1964. This year, 1990, is an historic one in the evolution of this nation's public policy towards persons with disabilities. The ADA is a comprehensive piece of civil rights legislation which promises a new future: a future of inclusion and integration, and the end of exclusion and segregation.

H.R. Rep. No. 101-485, pt. 3 at 26 (1990). "[D]rawing an analogy to the segregation of African-Americans, the House Report noted that 'segregation for persons with disabilities 'may affect their hearts and minds in a way unlikely ever to be undone.'" *L.C.*, 138 F.3d at 898.

Former Senator Lowell Weicker, the original Republican sponsor of the ADA, strenuously denounced the

application of the "separate but equal" notion to disabled individuals.

For years, this country has maintained a public policy of protectionism toward people with disabilities. We have created monoliths of isolated care in institutions and in segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal. It was not for blacks; it is not for the disabled.

*Americans With Disabilities Act, 1989: Hearings on S. 933 Before the Senate Comm. on Labor and Human Resources and the Subcomm. on the Handicapped, 101st Cong. 215 (1989).*

Other statements comparing disability discrimination to historic exclusionary practices directed at racial minorities and women abound in the ADA's legislative history, along with corresponding expressions of Congressional intent to integrate Americans with disabilities into the mainstream of society to the fullest extent possible. *See, e.g.,* 134 Cong. Rec. S5106, 5107-5108 (1988) (statement of Sen. Weicker, explaining bill's purpose as providing protections that parallel those afforded against discrimination on the basis of race, sex, religion and national origin); 135 Cong. Rec. E2812, E2813 (1989) (statement of Rep. Owens, comparing disability movement to the African-American civil rights struggles); 136 Cong. Rec. H2421, H2428 (1990) (statement of Rep. Bartlett, noting that ADA provides same protection available to others on the basis of race, sex, national origin and age); H2438 (statement of Rep. Edwards, stating that "'Separate but equal' is not civil rights"); H2441 (statement

of Rep. Brooks, noting that individuals with disabilities will have same protection provided to others against discrimination); H2445 (statement of Rep. Coleman, disabled individuals will receive same protections available to other minorities); H2447-H2448 (statement of Rep. Miller, ADA guarantees same rights provided to other minorities); 136 Cong. Rec. H2599, H2616 (1990) (statement of Rep. Glickman, comparing disability discrimination to discrimination on the basis of race and sex); H2639 (statement of Rep. Dellums, denouncing the separate but equal concept as applied to the disabled).

The plain language of the ADA makes it clear that Congress did not pass this law simply to express an hortatory preference, but rather mandated the integration of disabled individuals pursuant to its power to enforce the Fourteenth Amendment. In this respect, the ADA differs significantly from the Developmentally Disabled Assistance and Bill of Rights Act of 1975 (DDA), 42 U.S.C. §§ 6000-6009 (1998), which was the subject of the principal case cited by Petitioners, *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981). In *Pennhurst*, the Court held that the DDA was only intended to encourage integration, not to compel it. Specifically, the Court noted that the DDA contained no express invocation of Congress' power to enforce the Fourteenth Amendment, and the legislative history established that Congress did not intend to create enforceable duties. *See Pennhurst*, 451 U.S. at 15, 20-23.

The ADA differs greatly from the DDA in its history, structure, and purpose. The text begins with a finding that discrimination against individuals with disabilities often takes the form of "institutionalization" and "segregation." The ADA then expressly invokes Congress' "power to enforce



the fourteenth amendment" for the stated purposes of providing "a clear and comprehensive *mandate*" and "*enforceable* standards" for the elimination of discrimination against individuals with disabilities. 42 U.S.C. § 12101 (a)(3)-(b)(4) (emphasis added). Moreover, the ADA explicitly incorporates by reference the coordination regulations issued under section 504 of the Rehabilitation Act--which in turn mandate that recipients of federal financial assistance administer programs "in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 C.F.R. § 41.51(d); 42 U.S.C. § 12134(b). Because "[i]ntegration is fundamental to the purposes of the Americans with Disabilities Act," the Department of Justice complied with the congressional directive by including an express integration mandate in the ADA's implementing regulations. 28 C.F.R. Part 35, App. A. § 35.130. *See also* *L.C.*, 138 F.3d at 897-898; *Helen L.*, 46 F.3d at 332.

### III. THE AMERICANS WITH DISABILITIES ACT PROHIBITS THE UNNECESSARY SEGREGATION OF INDIVIDUALS WITH MENTAL DISABILITIES

Petitioners suggest that the ADA does not compel the State to desegregate mentally disabled individuals who are qualified for community placement "when appropriate treatment can also be provided to them in a State hospital." (Petitioners' Brief at i). Petitioners' "separate but equal" approach to individuals with mental disabilities, however, cannot withstand scrutiny in light of the history of discrimination against this group of Americans, the plain language of the ADA, the Act's legislative history, and the principles of civil rights law developed over the last four decades.

It is widely recognized that individuals with mental disabilities historically have suffered from state-imposed exclusionary practices comparable to prohibited race and gender discrimination. *See City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 450 (1985) (holding that zoning restrictions imposed on a group home for the mentally retarded reflected "an irrational prejudice against the mentally retarded"). As observed by Justice Marshall, "the mentally retarded have been subject to a 'lengthy and tragic history' of segregation and discrimination that can only be called grotesque." *Id.* at 461 (citations omitted).

Fueled by the rising tide of Social Darwinism, . . . [a] regime of state-mandated segregation and degradation soon emerged that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow. Massive custodial institutions were built to warehouse the retarded for life . . .

For the retarded, just as for Negroes and women, much has changed in recent years, but much remains the same; out-dated statutes are still on the books, and irrational fears or ignorance, traceable to the prolonged social and cultural isolation of the retarded, continue to stymie recognition of the dignity and individuality of retarded people.

*Id.* at 461-462, 467 (Marshall, J., concurring in part and dissenting in part).

Like the mentally retarded, the mentally ill, epileptics, persons with brain injuries, and other individuals with mental disabilities historically have been segregated in large human "warehouses." See generally *O'Conner v. Donaldson*, 422 U.S. 563 (1975) (addressing the unnecessary involuntary confinement of a mentally ill individual). Construction of custodial colonies for the mentally retarded followed the mid-nineteenth-century movement to build state institutions for the mentally ill. See Edward J. Larson, *Sex, Race and Science* 24 (1995). Mental health officials promoted eugenics as a way to rid society of the mentally insane and other "mental defectives." *Id.* at 24, 44.

Segregation has the same effects on disabled individuals as it has had on racial minorities and women. It sends a message of inequality, perpetuates stereotypes and forces these individuals to accept services in an isolated and inherently unequal environment. See, e.g., Timothy M. Cook, *The Americans With Disabilities Act: The Move to Integration*, 64 Temp. L. Rev. 393, 409-410 (1991) (citing additional sources). The conclusion reached in *Brown*, therefore, is also applicable to the unnecessary institutionalization of mentally disabled individuals. Such state-imposed segregation is per se discriminatory.

Indeed, Congress considered and rejected some of the same generalized concerns about extending the ADA's protections to individuals with mental impairments that Petitioners now put forth. See 135 Cong. Rec. S11173 (1989). As a result, the ADA's statutory language explicitly addresses Americans with "mental disabilities" and discrimination in the form of "institutionalization" and "segregation." 42 U.S.C. § 12101(a)(5). The Attorney General's regulations also include mental disabilities among the conditions covered by the Act and construe the ADA to

require community integration, where appropriate. See Chai Feldblum, *Antidiscrimination Requirements of the ADA*, in *Implementing the Americans with Disabilities Act* 38 (Lawrence O. Gostin & Henry A. Beyer, eds. 1992); 28 C.F.R. § 35.130. In light of the plain language of the ADA, its legislative history, and its implementing regulations, Petitioners' attempt to raise doubts regarding Congress' intent to mandate the integration of a mentally disabled individual who is qualified for community placement cannot withstand scrutiny. See *Pennsylvania Dept. of Corrections v. Yeskey*, 524 U.S. 206 (1998).

Moreover, the Court should reject the Petitioners' arguments for the same reasons that it has rejected similar rationalizations in other types of civil rights cases. Petitioners' assertion that the ADA does not require integration, that it merely forbids discrimination, is reminiscent of the attitude of those who, even after *Brown v. Board of Education*, could not quite accept the task of eliminating the vestiges of racial segregation. Because this type of state-imposed segregation is per se discriminatory, however, the argument fails in the disability context just as it did in the context of racial discrimination.

Petitioners' paternalistic excuses cannot justify segregation of the mentally disabled any more than they can justify the exclusion of women. In fact, it is this type of protectionism that has perpetuated the discriminatory isolation of women and disabled individuals in the past. Petitioners' effort to escape their obligations under the ADA ignores the fact that the statute was enacted to address these precise attitudes. The absence of an overtly malevolent motive simply cannot convert a segregationist practice into a neutral policy. See *United States v. Virginia*, 518 U.S. at



535-536; *International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187 (1991).

Just as Virginia cannot justify its exclusion of qualified women from VMI with "overbroad generalizations about the different talents, capacities, or preferences of males and females," *United States v. Virginia*, 518 U.S. at 533, Georgia cannot rely on generalized concerns regarding deinstitutionalization to segregate individuals who, like L.C. and E.W., have been found qualified for community placement. Furthermore, the Court of Appeals emphasized that it was not mandating "the deinstitutionalization of individuals with disabilities" *en masse* but only the integration of individuals whose treating professionals deem community placement to be appropriate. *L.C.*, 138 F.3d at 902.

Nor do Petitioners' financial considerations call for a reversal. "As the House Judiciary report explained, '[t]he fact that it is more convenient, either administratively or fiscally, to provide services in a segregated manner, does not constitute a valid justification for separate or different services . . .'" *L.C.*, 138 F.3d at 902. *Cf. Cedar Rapids Community Sch. Dist. v. Garret F.*, No. 96-1793, 1999 WL 104410 (U.S. March 3, 1999) (holding that financial concerns were not a defense to the integration and accommodation requirements of the Individuals with Disabilities Education Act). In any event, the Court of Appeals remanded for further consideration of the cost issue.

In sum, the Petitioners' argument runs counter to the stated goals of the ADA to eliminate the stereotypes and stigma flowing from the unnecessary institutionalization of disabled individuals. In light of the plain language of the ADA and fundamental civil rights principles developed over

the years, the conclusion reached by the Court of Appeals below is inescapable. The State's unnecessary segregation of an individual based on her mental disability violates the ADA, unless the State can prove on remand that the expense of community placement would fundamentally alter the services provided.

## CONCLUSION

The judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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No. 98-536

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IN THE  
SUPREME COURT OF THE UNITED STATES  
OCTOBER TERM, 1998

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TOMMY OLMSTEAD, ET AL.  
*Petitioners,*

*vs.*

L.C. AND E.W., EACH BY JONATHAN ZIMRING, AS  
GUARDIAN AD LITEM AND NEXT FRIEND,  
*Respondents.*

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ON WRIT OF CERTIORARI TO THE UNITED STATES  
COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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BRIEF OF *AMICI CURIAE*, DICK  
THORNBURGH AND THE NATIONAL  
ORGANIZATION ON DISABILITY IN SUPPORT  
OF RESPONDENTS

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328

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## TABLE OF CONTENTS

|   |    |
|---|----|
| Interest of <i>Amici Curiae</i> .....   | 1  |
| Summary of Argument .....   | 1  |
| Argument .....  | 4  |
| I. The Plain Language Of The ADA, Which<br>Incorporates The DOJ Integration Regulation,<br>Supports The Eleventh Circuit's Holding..... | 10 |
| II. The Attorney General's Interpretation Of<br>DOJ's ADA Title II Regulations Merits<br>Substantial Judicial Deference .....           | 13 |
| III. Pre-ADA Judicial Interpretation of Section<br>504 Was Not Uniform and, So, Provides No<br>Support for Petitioners' Argument.....   | 20 |
| Conclusion .....  | 27 |

## TABLE OF AUTHORITIES

## Cases

|  |               |
|--|---------------|
| <i>Alexander v. Choate</i> , 469 U.S. 287 (1985) .....   | 18, 21        |
| <i>Auer v. Robbins</i> , 117 S.Ct. 905 (1997) .....  | 18            |
| <i>Bazemore v. Friday</i> , 478 U.S. 385 (1986) .....  | 10            |
| <i>Bowles v. Seminole Rock &amp; Sand Co.</i> ,<br>325 U.S. 410 (1945) .....                         | 20            |
| <i>Bragdon v. Abbott</i> , 118 S.Ct. 2196 (1998) .....   | 13, 20        |
| <i>Brown v. Board of Education</i> , 347 U.S. 483 (1954) .....                                       | 10            |
| <i>Cedar Rapids Community School District<br/>v. Garret F.</i> , No. 96-1793 (March 3, 1999) .....   | 14            |
| <i>Clark v. Cohen</i> , 794 F.2d 79 (CA3 1986) .....   | 22            |
| <i>General Motors Corp. v. Tracy</i> , 519 U.S. 278 (1979) .....                                     | 10            |
| <i>Halderman v. Pennhurst State School and Hospital</i> ,<br>612 F.2d 84 (CA3 1979) (en banc) .....  | 25            |
| <i>Halderman v. Pennhurst State School and Hospital</i> ,<br>446 F. Supp. 1295 (E.D. Pa. 1978) ..... | <i>passim</i> |
| <i>Halderman v. Pennhurst State School and Hospital</i> ,<br>784 Supp. 215 (E.D. Pa. 1992) .....     | 23            |

|  |            |
|--|------------|
| <i>Helen L. v. DiDario</i> , 46 F.3d 325 (CA3) .....   | 18         |
| <i>Helvering v. Highland</i> , 124 F.2d 556 (CA4 1942) .....   | 23         |
| <i>Hornward Bound, Inc. v. Hissom Memorial<br/>Center</i> , No. 85-C-437-E, 1987 WL 27104<br>(N.D. Okl. July 24, 1987) ..... | 23         |
| <i>Jackson v. Fort Stanton Hospital &amp; Training School</i> ,<br>757 F. Supp. 1243 (D.N.M. 1990) .....                     | 22         |
| <i>Lorance v. AT&amp;T Technologies, Inc.</i> ,<br>490 U.S. 900 (1989) .....   | 10         |
| <i>Lorillard v. Pons</i> , 434 U.S. 575 (1978) .....   | 20         |
| <i>Lynch v. Maher</i> , 507 F. Supp. 1268 (D. Conn. 1981) .....  | 23         |
| <i>Menkowitz v. Pottstown Memorial Medical<br/>Center</i> , 154 F.3d 113 (CA3 1998) .....                                    | 4          |
| <i>O'Connor v. Consolidated Coin Caterers<br/>Corporation</i> , 116 S.Ct. 1307 (1996) .....                                  | 13         |
| <i>P.C. v. McLaughlin</i> , 913 F.2d 1033 (CA2 1990) .....   | 22         |
| <i>People First of Tennessee v. Arlington Developmental<br/>Center</i> , 878 F. Supp. 97 (M.D. Tenn. 1992) .....             | 22         |
| <i>Southeastern Community College v. Davis</i> ,<br>442 U.S. 397 (1979) .....  | 17, 18, 21 |



*Thomas Jefferson University v. Shalala*,  
512 U.S. 504 (1994)..... *passim*

*Traynor v. Turnage*, 485 U.S. 535 (1988) .....21

*United States v. Board of Commissioners of  
Sheffield, Alabama*, 435 U.S. 110 (1978) .....11

### Statutes

20 U.S.C. §3508.....5

29 U.S.C. §§ 621, *et seq.*.....12

29 U.S.C. § 701, *et seq.*..... *passim*

42 U.S.C. § 12101, *et seq.*..... *passim*

42 U.S.C. § 12132.....11

42 U.S.C. § 12134.....7

42 U.S.C. §12182.....12

42 U.S.C. § 2000.....7

### Regulations

5 C.F.R. § 900.....8

7 C.F.R. § 15.....8

10 C.F.R. §1040.....8

22 C.F.R. § 142.....8

28 C.F.R. § 35 (1991) .....9, 14

28 C.F.R. § 794 (1978) .....7

34 C.F.R. § 104.4 (1980) .....8

45 C.F.R. § 85.51 (1978) .....5

45 C.F.R. §1170.....8

### Miscellaneous

Executive Order No. 11,914, 43 F.R. 2132 (1978).....4

Executive Order No. 12,250, 45 F.R. 72995 (1980).....5

135 Cong. Rec. S10713 (Sept. 7, 1989).....25

136 Cong. Rec. H2447 (May 17, 1990).....25

H. Rep. No. 101-485(I) (1990) .....25

S. Rep. No. 101-116 (1989).....5

## INTEREST OF *AMICI CURIAE*

Dick Thornburgh served as Attorney General of the United States from 1988 to 1991. As Attorney General, he oversaw the preparation of draft legislation that Congress eventually passed as the Americans With Disabilities Act, he testified before Congress as it considered the legislation, and he supervised the promulgation of the Department of Justice regulations at issue in this case.

The National Organization on Disability ("NOD") promotes the full and equal participation of America's 54 million men, women and children with disabilities in all aspects of life. NOD was founded in 1982 at the conclusion of the United Nations International Year of Disabled Persons. NOD is the only national disability network organization concerned with all disabilities, all age groups and all disability issues.\*

## SUMMARY OF ARGUMENT

The Americans With Disabilities Act ("ADA"), 42 U.S.C. §§ 12101, *et seq.*, and the specific regulation at issue in this case, 28 C.F.R. § 35.130(d) (the "Integration Regulation"), define as unlawful discrimination the unnecessary segregation of persons with disabilities. Any contrary conclusion ignores the plain language of both the

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\* Both Petitioners and Respondents have consented to the filing of this brief, and letters of consent are on file with the Clerk of Court. No counsel for a party authored this brief in whole or in part, and no person or entity other than the named *amici* made a monetary contribution to the preparation of this brief.



statute and the regulation, the intent of Congress and this Court's well-established interpretive rules.

The Attorney General's interpretation of the Integration Regulation is both reasonable and consistent with congressional intent in enacting the ADA. The regulation requires that public entities, including the states, provide programs and services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." In this case, the Eleventh Circuit held that the Integration Regulation requires that, when a state has established both institution-based services and community-based services for persons with disabilities, the state must allow the recipient to receive services in the most-integrated setting. That holding and its interpretation of the applicable regulation are mandated by the plain language of the Integration Regulation and with the broad scope of prohibited discrimination intended by the drafters of the ADA.

Petitioners seek to have this Court reverse the Eleventh Circuit's opinion on three principal grounds. None of Petitioners' arguments is persuasive or supports the reversal of the Eleventh Circuit's decision.

First, Petitioners argue that the Attorney General's regulations somehow exceed the statutory grant of authority. In fact, in the ADA, Congress directed the Attorney General to model his regulations on regulations promulgated by the Department of Health, Education and Welfare ("HEW") to implement Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§ 701, *et seq.* (those regulations will be referred to throughout this brief as the "Coordination Regulations" in order to distinguish them from other HEW regulations relating to Section 504). The Attorney General did so and the

resulting regulation almost mirrors the model Congress prescribed.

Second, Petitioners contend that the Attorney General's current interpretation of the Integration Regulation warrants no deference from this Court because it is of recent vintage and inconsistent with her previous position. In fact, no Attorney General has ever offered an interpretation at variance with the DOJ's current view and the Department of Justice argued more than 20 years ago that Section 504 required the result Respondents urge in this case. There being no inconsistency in the Attorney General's position regarding a regulation her agency was charged to draft and enforce, this Court's precedents require substantial deference to the agency's interpretation of its own regulation.

Third, Petitioners argue that Congress' intent regarding the Integration Regulation may be discerned from pre-ADA judicial decisions interpreting Section 504. Petitioners seek to portray the Section-504 cases as uniform in their interpretation and contrary to the Eleventh Circuit's interpretation of the Integration Regulation. In fact, the pre-ADA case law is far from uniform and the interpretive maxim on which Petitioners rely thus has no application. When Congress acts against a background of diverse judicial interpretations, its reference to the statute that caused that judicial diversity cannot reasonably be viewed as a legislative endorsement of any particular judicial interpretation. Moreover, those cases involved different statutory language.

Accordingly, the decision of the Eleventh Circuit should be affirmed.<sup>1</sup>

## ARGUMENT

Congress' declaration of rights and obligations in the Americans With Disabilities Act ("ADA"), 42 U.S.C. §§ 12101, *et seq.*, was broad in its scope. *See Menkowitz v. Pottstown Memorial Medical Center*, 154 F.3d 113, 118 (CA3 1998). That mandate is best understood by reference to the history of the ADA and its regulations.

In 1973, Congress enacted the Rehabilitation Act, 29 U.S.C. §§ 701, *et seq.* Section 504 of that statute prohibited federal-fund recipients from discriminating against any qualified individual with a disability "solely by reason of her or his disability . . ." 29 U.S.C. § 794. In 1976, President Ford instructed the Department of Health, Education and Welfare ("HEW") to promulgate regulations for the enforcement of Section 504. Executive Order No. 11,914, 3 C.F.R. 117 (1977). On January 13, 1978, HEW published its regulations. 43 F.R. 2132 (1978). The HEW regulation described the forms of discrimination barred by Section 504 and included the following as a stand-alone provision:

Recipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons.

<sup>1</sup> This brief does not address the specific facts of the case presented for review because those facts will be described thoroughly by Respondents and other *amici*.

45 C.F.R. § 85.51(d) (1978) (the "Coordination Regulations"). A year later, Congress reorganized and renamed HEW into what is now known as the Department of Health and Human Services ("HHS"). 20 U.S.C. § 3508 (1979). In 1980, President Carter directed that leadership and coordination of non-discrimination laws be transferred from HHS to the Department of Justice ("DOJ"). Executive Order No. 12,250, 45 F.R. 72995 (1980). DOJ adopted HEW's Coordination Regulations and transferred them to 28 C.F.R. Part 41.

In the late 1980s, Congress recognized a need to broaden both the scope and application of laws prohibiting discrimination based on disability. From the beginning, Congress sought to insure that individuals with disabilities be integrated into everyday life:

there is a compelling need to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and for *the integration of persons with disabilities into the economic and social mainstream of American life.*

S. REP. No. 101-116 at 20 (1989) (emphasis added). In this environment, Congress drafted the ADA. After considerable debate, Congress enacted the ADA in 1990 and President Bush signed it into law in July of that year.

The ADA is a comprehensive law addressing discrimination against persons with disabilities in a variety of areas, including employment, public services and public accommodations provided by private entities. Title II, which



is at issue in this case, governs public services provided by the states. During the committee hearings and debates leading to the ADA's enactment, Congress heard from a great many sources, including then-Attorney General Dick Thornburgh:

Over 15 years have gone by since the Rehabilitation Act of 1973 conferred on Federal and federally assisted programs the responsibility to accommodate Americans with disabilities. In that time, the doors of opportunity have been opened to persons with disabilities.

Nevertheless, persons with disabilities are still too often shut out of the economic and social mainstream of American life.

*Hearing on HR 2273 Before the Sen. Subcommittee on Civil and Constitutional Rights, 101<sup>st</sup> Cong. 58 (statement of Attorney General Dick Thornburgh).*

Congress did not attempt to enumerate all forms of prohibited conduct in the text of Title II of the ADA. Instead, it directed the Attorney General to issue regulations within a year of the enactment of the ADA and it effectively incorporated those regulations by reference.

#### **(a) In general**

Not later than 1 year after July 26, 1990, the Attorney General shall promulgate regulations in an accessible format that implement this part. Such regulations shall not include any matter that is within the scope of the authority

of the Secretary of Transportation under section 12143, 12149, or 12164 of this title.

#### **(b) Relationship to other regulations**

Except for "program accessibility, existing facilities", and "communications", regulations under subsection (a) of this section shall be consistent with this chapter *and with the coordination regulations under part 41 of title 28, Code of Federal Regulations (as promulgated by the Department of Health, Education, and Welfare on January 13, 1978) applicable to recipients of Federal financial assistance under section 794 of Title 29.* With respect to "program accessibility, existing facilities", and "communications", such regulations shall be consistent with regulations and analysis as in part 39 of title 28 of the Code of Federal Regulations, applicable to federally conducted activities under section 794 of Title 29.

42 U.S.C. § 12134 (1990) (emphasis added).

The precision with which Congress prescribed the drafting of ADA regulations is both important and unusual.<sup>2</sup>

<sup>2</sup> Contrast the mandate in Section 12134 with that in Section 602 of the Civil Rights Act of 1964 ("Title VI"), 42 U.S.C. § 2000d-1. In Title VI, Congress directed federal agencies to promulgate regulations "to effectuate the provisions of section 2000d of this title." In that most general delegation, Congress neither gave more precise guidance nor pointed to models.

At the time Congress enacted the ADA, it could have chosen and incorporated into the statute a number of agency regulations interpreting the types of discrimination barred by Section 504. As noted, DOJ's coordination regulations, drawn from HEW's 1978 Coordination Regulations, offered one model. The Department of Education's regulations provided a somewhat different model. *See* 34 C.F.R. § 104.4 (1980).<sup>3</sup> Notably, the latter model includes the "most-integrated-setting" language as a qualification to other language that could be misunderstood to suggest that "separate-but-equal" programs meet the requirements of Section 504. In contrast, the HEW Coordination Regulations chosen by Congress established that the failure to provide services in the most appropriate integrated setting itself constituted a form of discrimination.

<sup>3</sup> Section 104.4 provides, in pertinent part, that

(2) For purposes of this part, aids, benefits, and services, to be equally effective, are not required to produce the identical result or level of achievement for handicapped and nonhandicapped persons, but must afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement, in the most integrated setting appropriate to the person's needs.

Some agencies used the HEW model. *See, e.g.,* 5 C.F.R. § 900.704 (Office of Personnel Management); 45 C.F.R. § 1170.12 (National Endowment for the Humanities). More agencies, however, opted for the model employed by the Department of Education. *See, e.g.,* 7 C.F.R. § 15b.4 (Department of Agriculture); 10 C.F.R. § 1040.63 (Department of Energy); 22 C.F.R. § 142.4 (Department of State).

In 1991, less than a year after passage of the ADA, Attorney General Thornburgh and DOJ complied with the congressional direction and promulgated regulations to interpret and enforce Title II of the ADA.<sup>4</sup> As instructed, DOJ patterned its regulations after the HEW Coordination Regulations. Indeed, one of those regulations provides as follows:

(d) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

28 C.F.R. § 35.130 (1991) (the "Integration Regulation"). That regulation is at the heart of this case.

Petitioners pursue three principal arguments in support of reversing the Eleventh Circuit's interpretation of the Integration Regulation. None is persuasive.

<sup>4</sup> During his tenure as Governor of Pennsylvania between 1979 and 1987, Mr. Thornburgh and his administration emphasized the need for community-based services for persons with disabilities and oversaw the closure of the Pennhurst State School and Hospital. As Attorney General, Mr. Thornburgh regarded the promulgation of the ADA regulations as a particular priority and, under his supervision, DOJ issued those regulations ahead of the congressional deadline.



**I. THE PLAIN LANGUAGE OF THE ADA, WHICH INCORPORATES THE DOJ INTEGRATION REGULATION, SUPPORTS THE ELEVENTH CIRCUIT'S HOLDING.**

Petitioners argue that the plain language of the ADA does not support the Eleventh Circuit's interpretation. For at least the following three reasons, they are mistaken.

First, this Court has already held that unnecessary segregation constitutes discrimination. See *Brown v. Board of Education*, 347 U.S. 483, 495 (1954) ("Therefore, we hold that the plaintiffs and others similarly situated for whom the actions have been brought are, by reason of the segregation complained of, deprived of the equal protection of the laws guaranteed by the Fourteenth Amendment."). There are, to be sure, distinctions between the setting of and the law applicable to *Brown* and this case, but the fundamental point retains its vitality: unlawful discrimination can exist without showing a disparity in treatment between a protected group and a non-protected group. When Petitioners write in their brief that "'discrimination' necessarily requires uneven treatment of similarly situated individuals," Pet. Br. at 21, they paint with too narrow a brush and ignore the teaching of *Brown* and other cases.<sup>5</sup>

<sup>5</sup> In support of their argument, Petitioners cite three cases that do not support the proposition that discrimination exists *only* when there is different treatment between similarly situated members of protected groups and non-protected groups. *General Motors Corp. v. Tracy*, 519 U.S. 278 (1997), was a Commerce-Clause case in a setting wholly different from this. *Lorance v. AT&T Technologies, Inc.*, 490 U.S. 900 (1989), and *Bazemore v. Friday*, 478 U.S. 385 (1986), merely noted that *one* way in which discrimination could be proven was by comparison between

Second, Petitioners incorrectly construe the DOJ regulations implementing Title II of the ADA as a sort of "frolic and detour." See Pet. Br. at 16. In reality, those regulations reacted to and implemented express direction in the ADA from Congress for the Attorney General to adopt regulations patterned after other existing regulations. 42 U.S.C. § 12134. He did precisely that, and the regulation at issue in this case is modeled on the prescribed Section-504 Coordination Regulations. Since the ADA regulation has become incorporated into the statute by reference, *United States v. Board of Commissioners of Sheffield, Alabama*, 435 U.S. 110, 135 (1978), there is no genuine question about whether Congress intended that the integration language in HEW's Section-504 Coordination Regulations become part of the ADA mandate.

Third, the ADA broadly prohibits "discrimination." 42 U.S.C. § 12132. Congress, in directing the Attorney General to issue regulations, made clear its view that discrimination against persons with disabilities takes many forms and cannot be simply defined:

Unlike the other titles of this Act, title II does not list all of the forms of discrimination that the title is intended to prohibit. Thus, the purpose of this section is to direct the Attorney General to issue regulations setting forth the forms of discrimination prohibited. The Committee intends that the regulations under title II incorporate interpretations of the

protected and non-protected persons. Neither case suggested in any sense that such comparisons are the only means to show discrimination.

term discrimination set forth in titles I and III of the ADA to the extent that they do not conflict with the Section 504 regulations.

H. REP. No. 101-485(I) at 52 (1990), *reprinted in* 1990 U.S.C.C.A.N. at 475.<sup>6</sup> The House committee also noted that Section 504 “has served not only to open up public services and programs to people with disabilities *but has also been used to end segregation.*” *Id.* at 49, 1990 U.S.C.C.A.N. at 472 (emphasis added). It is, therefore, clear that Congress viewed unnecessary segregation of persons with disabilities as discrimination and that Congress sought to prevent that form of discrimination.

Petitioners assert that “discrimination” refers only to different treatment between those who are members of a protected group and those who are not. Pet. Br. at 20. Although it is questionable whether such a bright-line definition could ever suffice, it most certainly does not in the context of persons with disabilities. The very term “disability” describes a broad spectrum. It is not unlike the group protected by the Age Discrimination in Employment Act, 29 U.S.C. §§ 621, *et seq.* In the context of age, the Court has recently made clear that there can be discrimination “because of” age even if the two persons compared are both

<sup>6</sup> Notably, among the statutory commands of Title III of the ADA is an integration mandate:

**(B) Integrated settings.** Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual.

42 U.S.C. § 12182.

in the protected class. *O'Connor v. Consolidated Coin Caterers Corporation*, 116 S.Ct. 1307, 1310 (1996) (emphasis original) (“The fact that one person in the protected class has lost out to another person in the protected class is thus irrelevant, so long as he has lost out *because of his age.*”). In the same sense, given the continuum both of type and severity of disability, it is possible to discriminate against a person with disabilities by treating him somehow differently from another person with disabilities. The comparison to non-disabled persons is a useful, but not a necessary, yardstick. *See O'Connor*, 116 S.Ct. at 1310.

## II. THE ATTORNEY GENERAL’S INTERPRETATION OF DOJ’S ADA TITLE II REGULATIONS MERITS SUBSTANTIAL JUDICIAL DEFERENCE.

There is, then, the question of whether the Court should afford deference to the Attorney General’s interpretation of the ADA Title II regulations.

The Court has already held that DOJ’s regulations implementing Title III of the ADA are due judicial deference:

As the agency directed by Congress to issue implementing regulations, to render technical assistance explaining the responsibilities of covered individuals and institutions and to enforce Title III in court, the [DOJ’s] views are entitled to deference.

*Bragdon v. Abbott*, 118 S.Ct. 2196, 2209 (1998) (citations omitted). The Court has also explained that



[o]ur task is not to decide which among several competing interpretations best serves the regulatory purpose. Rather, the agency's interpretation must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation.

*Thomas Jefferson University v. Shalala*, 512 U.S. 504, 512 (1994) (quotations omitted); *see also*, *Cedar Rapids Community School District v. Garret F.*, No. 96-1793 at typeset 8-9 n.6 (March 3, 1999).

Petitioners' response to this basic principle is to assert that "[t]he Attorney General's present litigation position in the end represents a stark and unexplained departure from prior interpretations of § 504 and the ADA." Pet. Br. at 42. It is true that "an agency's interpretation of a statute or regulation that conflicts with a prior interpretation is entitled to considerably less deference than a consistently held agency view." *Thomas Jefferson University*, 512 U.S. at 515 (quotations omitted). However, Petitioners have properly described the maxim but then misapplied it.

Petitioners argue that the Attorney General has changed her position about the meaning<sup>7</sup> of the Integration Regulation, but they offer no support for that proposition. Instead, they point to a number of statements by DOJ that offer examples of how the Integration Regulation should be applied. *See* 28 C.F.R. Part 35 (App. D, 11a, 16a-20a), *The Americans With Disabilities Act, Title II Technical Assistance Manual, Covering State and Local Government Programs and Services* (1993) (the "Technical Assistance Manual"). The only argument Petitioners make about those statements is that they do not include the interpretation the

DOJ espouses in this case. Pet. Br. at 41-42.<sup>7</sup> That is not, however, an inconsistency. In *Thomas Jefferson University*, the Court was offered (and rejected) a similar argument.

The intermediary letter detailed various categories and amounts of educational expenses . . . but did not mention the anti-redistribution limitation. Petitioners' attempt to infer from that silence the existence of a contrary policy fails because the intermediary letter did not purport to be a comprehensive review of all conditions that might be placed on reimbursement of educational costs. . . . It is not surprising, then, that the letter did not address the anti-redistribution principle, and the mere failure to address it here hardly establishes an inconsistent policy on the part of the Secretary.

512 U.S. at 516 (emphasis added). The same may be said of previous DOJ statements about the meaning of the ADA integration regulation. None of the statements Petitioners point to purports to be exhaustive and Petitioners' reliance on DOJ's silence to suggest an inconsistent application is no more compelling than was the petitioners' similar reliance in *Thomas Jefferson University*. In fact, then, there is no inconsistency in DOJ's interpretation of the ADA integration regulation.

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<sup>7</sup> Petitioners' argument is wrong for another reason. The Technical Assistance Manual offers examples for a different subsection of the regulation than the one in which the integration requirement is found.

To the contrary, DOJ has been consistent in its interpretation of that regulation in the circumstance presented in this case. When the *Pennhurst* case was first making its way to this Court, DOJ filed a brief in the Third Circuit addressing, *inter alia*, the requirements of Section 504.

The services provided for Pennhurst residents are unnecessarily separate both from the community and from community mental retardation services which the district court found were more conducive to "normalization," a principle which defendants have accepted.

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Where the Congressional intent expressed is to broadly protect handicapped persons, and the discrimination is well within the Congressionally authorized regulations, the question is not – as defendants would state it – whether Congress has declared that all institutions for the mentally retarded should be closed forthwith, but whether Congress intended to allow federal funds to subsidize conditions such as those at Pennhurst, especially where the institutionalization results in separation of mentally retarded persons for no permissible reason. In our view, that is "discrimination," and a violation of Section 504 if it is supported by federal funds.

Brief for the United States, *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564 and 78-1602, at 40 and 45 (filed October 2, 1978). After this Court rendered

its first *Pennhurst* decision and remanded the case to the court of appeals, the Third Circuit had occasion again to consider the application of Section 504. In its brief, DOJ modified its position, but not in any way material to this case.

At a minimum, Section 504 compels the state to determine that the person committed to an institution on account of handicap is not "otherwise qualified" to participate in some other available federally assisted program or activity providing more appropriate care and treatment. In the context of this case, this means that before determining that a handicapped individual should be placed in one federally assisted program rather than another the state must make an individualized judgment, based on reasoned professional advice.

The issue here is not whether Section 504 would require Pennsylvania to create or expand a system of community facilities. Nor does the United States here urge any such interpretation of the statute. Indeed, *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), suggests that Section 504 does not create such an obligation. But in this case, Pennsylvania already maintains such a system. In such circumstances, Pennsylvania violates section 504 by indiscriminately subjecting handicapped persons to Pennhurst without first making an individual reasoned professional judgment as



to the appropriate placement for each such person among all available alternatives.

Brief for the United States, *Halderman v. Pennhurst State School and Hospital*, Nos. 78-1490, 78-1564 and 78-1602, at 26-27 (filed October 14, 1981). In other words, DOJ argued that Section 504 required an interpretation similar to the one Respondents have offered in this case for the ADA regulation.<sup>8</sup>

DOJ's *Pennhurst* briefs provide support for a number of conclusions. Foremost is the inescapable conclusion that the current DOJ interpretation of Section 504 (and the ADA) is not a recent creation born of politics or activism.<sup>9</sup>

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<sup>8</sup> Moreover, DOJ's modified view relied on an interpretation of *Southeastern Community College v. Davis*, 442 U.S. 397 (1979), that the Court essentially retracted in *Alexander v. Choate*, 469 U.S. 287, 301 n.20 (1985).

<sup>9</sup> In a number of cases in which she has provided briefs as an *amicus*, the Attorney General has offered courts the same interpretation of the ADA Integration Regulation urged by Respondents in this case. See, e.g. *Helen L. v. DiDario*, 46 F.3d 325 (CA3) cert. denied, 116 S.Ct. 64 (1995). The Attorney General's interpretation is not, as Petitioners would characterize it, merely a "litigating position." The Court rejected a similar argument just two years ago in *Auer v. Robbins*, 117 S.Ct. 905, 912 (1997) (citation omitted):

Petitioners complain that the Secretary's interpretation comes to us in the form of a legal brief; but that does not, in the circumstances of this case, make it unworthy of deference. The Secretary's position is in no sense a "post hoc rationalizatio[n]" advanced by an agency seeking to defend past agency action against attack. There

The Attorney General has determined that the regulations issued by her agency require that, under the ADA, where a state has a choice between institutionalized treatment and community-based treatment, the recipient is entitled to receive services in the most-integrated setting appropriate to his needs. That interpretation is an abundantly reasonable one. It is both consistent with the regulation, with the ADA and with the legislative history.<sup>10</sup>

The Court should apply its well-established rule that it "give[s] substantial deference to an agency's interpretation of its own regulations." *Thomas Jefferson University*, 512 U.S. at 515. The Court has held that its role is not to weigh the competing interpretations and substitute its judgment for that of the agency. *Id.* In *Thomas Jefferson University*, the Court explained that

[t]he Secretary's interpretation of the anti-distribution principle is thus far more consistent with the regulation's unqualified language than the interpretation advanced by petitioner. ***But even if this were not so, the Secretary's construction is, at the very least, a reasonable one, and we are required to afford it "controlling weight."***

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is simply no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter in question.

<sup>10</sup> As Respondents and other *amici* point out, the interpretation of the Attorney General and of the Eleventh Circuit does not impose an undue financial burden on the states and may, instead, result in a net savings.

512 U.S. at 515 (emphasis added) (quoting *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)).<sup>11</sup>

### III. PRE-ADA JUDICIAL INTERPRETATION OF SECTION 504 WAS NOT UNIFORM AND, SO, PROVIDES NO SUPPORT FOR PETITIONERS' ARGUMENT.

Petitioners correctly point to the rule of construction that, when there is uniformity in the administrative and judicial interpretation of statutory or regulatory language, the repetition of that language in a subsequent statute or regulation suggests an intent to incorporate those uniform interpretations as well. *Abbott*, 118 S.Ct. at 2208.

Again, Petitioners have correctly recited the rule but then misapplied it. The rule applies when there has been *uniform* interpretation of the language. See *Abbott*, 118 S.Ct. at 2207-8 ("Every court which addressed the issue before the ADA was enacted in July 1990, moreover, concluded that asymptomatic HIV infection satisfied the Rehabilitation Act's definition of a handicap . . . We find the uniformity of the administrative and judicial precedent construing the definition significant."); *Lorillard v. Pons*, 434 U.S. 575,

<sup>11</sup> Petitioners' argument seeks to reverse the appropriate burdens. The Court has held that it is to afford substantial deference to the agency interpretation unless it is inconsistent with the agency's past interpretations. *Thomas Jefferson University*, 512 U.S. at 515. Petitioners ask the Court to find that the Attorney General's interpretation is due deference only if she can demonstrate that her interpretation has been consistently held by DOJ. Given the DOJ position in *Pennhurst* 20 years ago, even if Petitioners' theory represented the proper legal standard, the current DOJ standard should receive deference.

580-81 (1978) (" . . . every court to consider the issue had so held"). In the case of the Section-504 integration regulation, one could not credibly claim that there was uniform judicial interpretation of that regulation in the years leading up to the enactment of the ADA.

Petitioners first point to this Court's pre-ADA construction of Section 504. The Court, however, has never addressed the Coordination Regulations and none of the decisions cited by Petitioners considers the issue presented in this case.<sup>12</sup>

Petitioners then address lower-court decisions and broadly announce that

<sup>12</sup> *Traynor v. Turnage*, 485 U.S. 535 (1988), merely noted that a central purpose of Section 504 was to assure even-handed treatment. It did not address every purpose of Section 504, it did not address the HEW Coordination Regulations and it did not even inferentially address the issue presented in this case. *Alexander v. Choate* has no application at all. That case stands for the proposition that a plaintiff does not state a claim of disparate-impact discrimination merely by noting that a uniformly distributed benefit need not bring about the same result for each individual. In *Davis*, the Court considered whether a college had an affirmative obligation under Section 504 to modify an existing program to, in effect, create a new program to accommodate a hearing-impaired applicant. The Court noted that "[w]e do not suggest that the line between a lawful refusal to extend affirmative action and illegal discrimination against handicapped persons always will be clear." 442 U.S. at 412. And, of course, this Court explained and limited the language of *Davis* in *Alexander v. Choate*. 469 U.S. at 301 n.20.



Prior to the 1990 passage of Title IIA of the ADA, many lower courts were invited to adopt an affirmative integration or "least restrictive treatment" requirement under § 504. None did.

Pet. Br. at 25-26. Petitioners offer a list of cases presumably in support of their assertion. That list, however, mischaracterizes many of the cases and omits others. It therefore provides small comfort for Petitioners' claim.

For example, three of the cases Petitioners cite were decided *after* Congress enacted and President Bush signed the ADA into law in July of 1990. See, e.g., *P.C. v. McLaughlin*, 913 F.2d 1033 (CA2 1990) (decided on September 6, 1990); *People First of Tennessee v. Arlington Developmental Center*, 878 F. Supp. 97 (M.D. Tenn. 1992); and *Jackson v. Fort Stanton Hospital & Training School*, 757 F. Supp. 1243 (D.N.M. 1990) (decided in December 1990), *rev'd on other grounds*, 964 F.2d 980 (CA10 1992). One of the decisions cited by Petitioners actually held that Section 504 requires a most-integrated environment. See *Jackson*, 757 F. Supp. at 1299 ("Where reasonable accommodations in community programs can be made, defendants' failure to integrate severely handicapped residents into community programs which presently serve less severely handicapped residents violated § 504.").<sup>13</sup>

<sup>13</sup> Further, a number of the cases Petitioners cite merely held that the states have no affirmative obligation to provide services. See, e.g., *Clark v. Cohen*, 794 F.2d 79, 84 n.3 (CA3 1986). That is not the issue in this case. In addition, none of the courts cited in Petitioners' brief addressed the HEW Coordination Regulations,

Moreover, Petitioners have omitted from their brief a number of lower-court decisions that found a "most-integrated" environment requirement in Section 504. For example, the district court in *Pennhurst* found that Section 504 prohibits the sort of unnecessary segregation complained of in this case. *Halderman v. Pennhurst State School and Hospital*, 446 F. Supp. 1295 (E.D. Pa. 1978); *aff'd on other grounds*, 612 F.2d 84 (CA3 1979); *rev'd on other grounds*, 451 U.S. 1 (1981). The court of appeals in *Pennhurst* did not address Section 504 and, accordingly, this Court had no opportunity to address the question.<sup>14</sup> In *Homeward Bound, Inc. v. Hissom Memorial Center*, No. 85-C-437-E, 1987 WL 27104 (N.D. Okl. July 24, 1987), the court held that "Section 504 prohibits unnecessarily segregated services for retarded persons." See, also, *Lynch v. Maher*, 507 F. Supp. 1268 (D. Conn. 1981).

Even a brief survey of the pre-ADA case law demonstrates that there was no "uniformity" among the lower courts on the Section-504 integration mandate. In the end, Petitioners' reliance on the notion that Congress ratified any particular judicial interpretation of Section 504 strains reason and stretches the rationale of that interpretive rule to the breaking point. See *Helvering v. Highland*, 124 F.2d 556, 561 (CA4 1942) ("Certainly, lack of uniformity in prior court

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most likely because the defendants in those cases were not bound by that iteration of the Section 504 regulations.

<sup>14</sup> Indeed, although the *Pennhurst* case gave rise to two decisions of this Court and innumerable published decisions by the lower courts, the district court's Section 504 conclusion retains its vitality. See *Halderman v. Pennhurst State School and Hospital*, 784 F. Supp. 215, 224 (E.D. Pa. 1992).

decisions . . . preclude[s] any presumption of Congressional approval of judicial interpretations . . . by reenactment.”).<sup>15</sup>

Indeed, although Congress’ intent cannot fairly be gleaned from any particular pre-ADA court decision, it can be discerned in the legislative history. Although it is anticipated that Respondents and other *amici* will address the legislative history of both Section 504 and the ADA in detail, it is worth briefly noting that both the committee reports preceding enactment of the ADA and the legislative findings accompanying the ADA support Respondents’ position. For example, the House Committee on Public Works and Transportation explained that

By prohibiting discrimination against persons with disabilities in programs and activities of the federal government and by recipients of federal financial assistance, Section 504 of the Rehabilitation Act has served not only to open up public services and programs to people with disabilities but it has also been used to end segregation. The purpose of Title II is to continue to break down barriers to the integrated participation of people with disabilities in all aspects of community life.

H. REP. NO. 101-485(I) at 50 (1990), *reprinted in* 1990 U.S.C.C.A.N. at 472-73. Congressman Miller, who was one of the sponsors of the ADA in the House of Representatives, explained that

<sup>15</sup> Petitioners’ argument is rendered all the more tenuous by the fact that Section 504 included the modifier “solely” to its prohibition and Congress did not include that word in the ADA.

. . . it has been our unwillingness to see all people with disabilities that has been the greatest barrier to full and meaningful equality. Society has made them invisible by shutting them away in segregated facilities.

136 CONG. REC. H2447 (daily ed. May 17, 1990) (Statement of Rep. Miller). Senator Harkin, a sponsor in the Senate, explained that the ADA

guarantees individuals with disabilities the right to be integrated into the economic and social mainstream of society; segregation and isolation by others will no longer be tolerated.

135 CONG. REC. S10713 (daily ed. Sept. 7, 1989) (statement of Sen. Harkin).<sup>16</sup>

Finally, the legislative findings that accompany the ADA support Respondents’ argument.

The Congress finds that -

(1) some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older;

<sup>16</sup> Many in Congress understood Section 504 to bar such isolation and segregation. See *Halderman v. Pennhurst State School and Hospital*, 612 F.2d 84, 108 n.30 (CA3 1979) (en banc) (collecting statements from the Congressional Record).



(2) *historically, society has tended to isolate and segregate individuals with disabilities*, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;

(3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, *institutionalization*, health services, voting, and access to public services;

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(5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, *segregation*, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;

42 U.S.C. § 12101 (emphasis added).

In the end, there is simply no support in the pre-ADA cases or in the legislative history of the ADA for Petitioners' interpretation of the legislative intent underlying the Integration Regulation.

## CONCLUSION

*Amici curiae* Dick Thornburgh and the National Organization on Disability respectfully request that the Court affirm the decision of the Eleventh Circuit.

Respectfully submitted,

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No. 98-536

**In the Supreme Court of the United States****OCTOBER TERM, 1998****TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF  
HUMAN RESOURCES, ET AL., PETITIONERS,****v.****L.C., BY JONATHAN ZIMRING,  
GUARDIAN AD LITEM AND NEXT FRIEND, ET AL.****ON WRIT OF CERTIORARI  
TO THE UNITED STATES COURT OF APPEALS  
FOR THE ELEVENTH CIRCUIT****BRIEF FOR AMICI CURIAE AMERICAN  
ASSOCIATION ON MENTAL RETARDATION, ET AL.,  
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## TABLE OF CONTENTS

|   |    |
|---|----|
| Interests of the Amici Curiae .....   | 1  |
| Summary of Argument .....   | 6  |
| Argument.....   | 8  |
| I. Congress Determined that Unnecessary Segregation in<br>Institutions is a Prohibited Form of Discrimination .....                   | 8  |
| A. The Movement Away From Needless<br>Institutionalization .....  | 8  |
| B. Community Living Benefits Persons Who Have<br>Mental Disabilities; Unnecessary<br>Institutionalization Harms Them.....             | 12 |
| II. The ADA Represents the Culmination of Federal<br>Policy Fostering Community-Based Services for<br>Persons with Disabilities ..... | 16 |
| III. Affirming the Judgment Below Poses No Risk of<br>Disrupting State Programs or Budgets .....                                      | 20 |
| A. Most States Have Already Committed Themselves<br>to an Official Policy of Community Treatment and<br>Habilitation .....            | 20 |
| B. Community Care Costs Less Than<br>Institutionalization .....   | 26 |
| Conclusion .....  | 30 |



## TABLE OF AUTHORITIES

### CASES

|  |           |
|--|-----------|
| <i>Alexander v. Choate</i> ,<br>469 U.S. 287 (1985) .....  | 17        |
| <i>Brown v. Board of Education</i> ,<br>347 U.S. 483 (1954) .....                                | 10        |
| <i>City of Cleburne v. Cleburne Living Center, Inc.</i> , 473<br>U.S. 432 (1985) .....           | 8, 10, 13 |
| <i>Halderman v. Pennhurst State School &amp; Hospital</i> , 612<br>F.2d 84 (3d Cir. 1979) .....  | 19        |
| <i>Halderman v. Pennhurst State School &amp; Hospital</i> , 673<br>F.2d 647 (3d Cir. 1982) ..... | 19        |
| <i>Helen L. v. DiDario</i> ,<br>46 F.3d 325 (3d Cir. 1995) .....                                 | 27, 28    |
| <i>Plessy v. Ferguson</i> ,<br>163 U.S. 537 (1896) .....   | 10        |
| <i>School Board v. Arline</i> ,<br>480 U.S. 273 (1987) .....                                     | 17        |

### STATUTORY AND REGULATORY PROVISIONS

|  |        |
|--|--------|
| Developmental Disabilities Assistance and Bill of Rights<br>Act, Pub. L. No. 94-103, 89 Stat. 486 (1975) .....                           | 16, 17 |
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*In the Supreme Court of the United States*

OCTOBER TERM, 1998

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No. 98-536

TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF  
HUMAN RESOURCES, ET AL., PETITIONERS,

v.

L.C., BY JONATHAN ZIMRING,  
GUARDIAN AD LITEM AND NEXT FRIEND, ET AL.

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*ON WRIT OF CERTIORARI  
TO THE UNITED STATES COURT OF APPEALS  
FOR THE ELEVENTH CIRCUIT*

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**BRIEF FOR AMICI CURIAE AMERICAN  
ASSOCIATION ON MENTAL RETARDATION, ET AL.,  
IN SUPPORT OF RESPONDENTS**

---

**INTERESTS OF THE AMICI CURIAE<sup>1</sup>**

The AIDS Legal Referral Panel provides legal advocacy for people with HIV/AIDS regarding healthcare, housing, autonomy and freedom from discrimination.

The American Association of Retired Persons is a not-for-profit organization serving over 32 million persons aged fifty and older, dedicated to promoting the independence and dignity of individuals as they grow older.

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<sup>1</sup> The parties have consented to the filing of this brief under S. Ct. R. 37.2, and their letters of consent have been lodged with the Clerk of the Court. Pursuant to S. Ct. R. 37.6, *amici* state that counsel for a party did not author this brief in whole or in part and that no one other than *amici*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

The American Association on Mental Retardation is the nation's oldest and largest interdisciplinary organization of professional and other persons who work exclusively in the field of mental retardation. AAMR promotes progressive policies, sound research, effective practices, and human rights for people with intellectual disabilities.

The American Network of Community Options and Resources is a nationwide association of over 650 private agencies that provide support and services to more than 150,000 people with mental retardation and other disabilities.

The American Orthopsychiatric Association is a multidisciplinary organization that advocates for sound mental health research, practice and policy.

The American Psychiatric Nurses Association provides leadership to advance the psychiatric mental health nursing profession, and works to shape health policy for the delivery of mental health services. Its constituency knows first-hand what it means to provide services to individuals in institutional and community settings.

The American Psychological Association is the major association of psychologists in the United States. Its membership includes the vast majority of psychologists holding doctoral degrees from accredited universities.

The Americans with Disabilities Association, Inc. works on developing Georgia laws that protect the rights of persons with disabilities and encourage integration of persons with disabilities.

The Arc of the United States, through its more than 1,000 state and local chapters, is the largest national voluntary organization devoted solely to the welfare of people with mental retardation and their families. The Arc has vigorously challenged attitudes and public policy, based on false stereotypes, that have encouraged the segregation of people with mental retardation.

The Autism Society of America, with over 24,000 members and 240 chapters, is the nation's leading source of information and referral services on autism.

The Brain Injury Association, Inc., is a national, non-profit organization dedicated to brain injury prevention, research, educa-

tion, and advocacy on behalf of persons with brain injuries. It serves persons with brain injury, their families and caregivers in all 50 states.

Catholic Charities, USA, is a national association of 1,400 local independent social service organizations that annually provide social services to 90,000 people with disabilities, among others. Our staff and volunteers believe, based on years of experience in provision of services, that community-based services are typically superior to institutional care for persons with disabilities in both quality of care and dignity of the individual.

Disability Rights Education and Defense Fund, Inc. is a national disability civil rights law and policy organization on behalf of Americans with disabilities.

The Epilepsy Foundation of America advances the interests of Americans with epilepsy and seizure disorders. Since its inception, the Foundation has stood against the stigma and estrangement associated with seizures.

The Georgia Advocacy Office has been designated by the state to provide protection and advocacy for people with developmental disabilities, mental illness, and other disabilities.

The Georgia Rural Urban Summit is a statewide advocacy group that promotes cooperation among diverse constituencies, including disabled persons, their families and communities.

The International Association of Psychosocial Rehabilitation Services is dedicated to the promotion, protection, and improvement of services that facilitate the adjustment of persons with psychiatric disabilities into communities. Its members include agencies, mental health practitioners, policy makers, family groups, and consumer organizations.

The International Brain Injury Association provides international leadership for individuals and organizations concerned with advancing opportunities for persons with brain injury.

The Joseph P. Kennedy, Jr. Foundation is the only major, private foundation that has dedicated its resources over the past 50 years to improving the lives of persons with mental retardation.



The Mental Health Association of Georgia is dedicated to improving the lives of people with mental illness.

The National Association for Rights Protection and Advocacy includes recipients of mental health and developmental disabilities services; lay, professional and self-advocates; family members; service providers; disability rights attorneys; and teachers at schools of law, social work and public policy. It is dedicated to promoting the preferred options of people who have been labeled mentally disabled.

The National Association of Protection and Advocacy Systems is a membership organization of state protection and advocacy agencies created by federal law to provide representation for all persons with disabilities. NAPAS advocates for the inclusion of persons with disabilities in all areas of life.

The National Association of Social Workers is a professional membership organization with more than 155,000 members. NASW believes that persons with disabilities are entitled to live in environments that maximize independence and self-determination.

The National Association of the Deaf, whose members are deaf and hard-of-hearing adults, parents of deaf and hard-of-hearing children, and professionals, works to safeguard the civil rights of deaf and hard-of-hearing Americans.

The National Catholic Office for Persons with Disabilities was established in 1982 as the voice of the Catholic Church in promoting the membership of people with disabilities in the church and society.

The National Council for Community Behavioral Healthcare is the nation's largest membership organization dedicated to ensuring appropriate and affordable community mental health and addiction services. Its membership includes providers of inpatient, outpatient, and residential care; partial hospitalization programs; psychiatric rehabilitation services; state and local policy advocates; and managers of state and county systems of care.

The National Down Syndrome Congress, a national organization of parents, professionals, and persons with Down syndrome, seeks to advance the rights of persons with Down syndrome and to promote their participation in all aspects of community life.

NISH (formerly National Industries for the Severely Handicapped) maximizes employment opportunities for people with severe disabilities. NISH supports civil rights for persons with disabilities in all areas to promote independent living opportunities and full integration into society.

The National Depressive and Manic-Depressive Association is dedicated to educating consumers, families, professionals and the public about depressive and manic-depressive illnesses; fostering self-help for consumers and families; eliminating discrimination and stigma; and advocating for research toward the elimination of these illnesses.

The National Mental Health Association is a national organization with over 330 affiliates dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness, as well as respect, dignity and opportunities for persons with disabilities.

The National Senior Citizens Law Center advocates for the independence and well-being of low-income, elderly individuals, as well as persons with disabilities.

North Georgia Wheelers sponsors a free literacy program for members of the disability community in Georgia, including children and youth in nursing homes and institutions.

The Rehabilitation Engineering and Assistive Technology Society of North America is an interdisciplinary association, the purpose of which is to improve the potential of people with disabilities to live and work in the community.

Shepherd Center is a Georgia specialty hospital serving persons who have experienced catastrophic illness such as multiple sclerosis and other neuromuscular disorders. Our mission is to assist these individuals in returning to the community.

The Statewide Independent Living Council of Georgia promotes the equal participation of people with disabilities within their communities. The Council is run by and for people with disabilities.

Volunteers of America is one of the nation's largest and most comprehensive human service organizations. It currently operates 43 programs providing services to over 2,400 people with devel-

opmental disabilities, including independent living training, supported and assisted living, and residential care.

United Cerebral Palsy Associations, Inc., with 150 affiliates in 43 states, seeks to advance independence, productivity and community participation of persons with cerebral palsy and other severe disabilities.

### SUMMARY OF ARGUMENT

Like other forms of discrimination, segregation based on mental disability injures both those whose disability subjects them to discriminatory treatment and the broader interests of the public. In interpreting the Americans with Disabilities Act ("ADA") and the Integration Regulation (28 C.F.R. § 35.130(d) (1998)) to bar such segregation where not necessary, the court of appeals effectuated both legislative intent and widely accepted professional standards. Persons who are served in a community-integrated setting make qualitatively greater progress in such a setting than when confined in an institution. For these individuals, including the respondents in this case, institutionalization is a formula for stagnation or decay, preventing participation in mainstream interactions that non-disabled persons take for granted. Furthermore, such substandard results come at a high cost, not only for the individual's well-being, but for the public treasury—the available data convincingly demonstrate that community placement represents a lower-cost solution than institutionalization. Thus, two mutually reinforcing rationales undergird the legislative determination to discourage needless institutionalization: community assistance is both more effective and less costly.

I. Undersigned *amici* believe that an appreciation of the historical context in which this dispute has arisen strongly counsels affirmance of the judgment below. In decades past, individuals with mental disabilities suffered under a dehumanizing regime of forced institutionalization. The needless segregation of individuals with disabilities, often achieved by shuttering them behind the walls of stultifying and abusive state institutions, represented an invidious legacy that Congress plainly intended to reverse in the ADA. The legislative purpose is supported by a vast body of literature recognizing that treating persons with mental disabilities in

an integrated community setting yields demonstrably superior results.

II. The mandate for integration found in the ADA—a landmark statute enacted with near-unanimous support from both parties in Congress, championed and signed by a Republican President—becomes all the clearer when considered alongside previous federal civil rights statutes. For more than three decades, the course of federal legislation has pointed in a single direction—away from unnecessary segregation and isolation of persons with disabilities, and toward their full integration into ordinary community life. The ADA's express declaration that unnecessary segregation is a prohibited form of discrimination against persons with disabilities represents the culmination of decades of legislative advancement toward the long-term goal of integrating Americans with disabilities into the community.

III. Affirmance of the judgment below will manifest fidelity to Congress' policy decisions and is consistent with the proper implementation of state programs for persons with disabilities. The majority of states already have committed themselves, by statute, regulation, or funding policy, to serving persons with disabilities in integrated community settings. Indeed, Petitioners' home state of Georgia has itself undertaken "to provide community-based alternatives to total institutional care so that mentally retarded individuals can continue to live in their home communities." Ga. Code Ann. § 37-5-2 (1982). Accordingly, applying the ADA's mandate for community integration is fully harmonious with, not in conflict with, the declared policies of the states. Nor does the decision below threaten an explosion in state expenses for treating persons with disabilities. As Congress was aware when it enacted the ADA, and as numerous studies have shown, treatment or habilitation of persons with disabilities in an integrated community environment is *less* costly to the states on average than institutionalization.



## ARGUMENT

### I.

#### CONGRESS DETERMINED THAT UNNECESSARY SEGREGATION IN INSTITUTIONS IS A PROHIBITED FORM OF DISCRIMINATION

##### A. The Movement Away From Needless Institutionalization

The unnecessary confinement of persons with disabilities is a tragic historical fact that Congress has in recent decades sought to ameliorate. To appreciate the significance of the ADA and its mandate for integration, a historical overview is critical. Viewed from the perspective history provides, the ADA represents a decisive rejection by Congress of needless institutionalization.

The discrimination against, and segregation of, individuals with mental illness, mental retardation, and developmental disabilities<sup>2</sup> was widely justified in the late 19th and early 20th centuries by a body of pseudoscientific literature that proclaimed such persons to be subhuman. As Justice Marshall recounted it, during this period,

social views of the retarded underwent a radical transformation. Fueled by the rising tide of Social Darwinism, the "science" of eugenics, and the extreme xenophobia of those years, leading medical authorities and others began to portray the "feeble minded" as a "menace to society and civilization . . . responsible for many, if not all, of our social problems."

*City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 461-462 (1985) (Marshall, J., concurring in part and dissenting in

<sup>2</sup> Individuals with mental illness and individuals with mental retardation comprise two distinct, although sometimes overlapping, populations that share comparable histories of segregation in institutions and social stigmatization. The meaning and importance of the ADA is substantially identical for both groups, and the mention of one form or another of mental disability throughout this brief should not be taken as a substantive limitation of the argument to that particular disability.

part) (footnotes omitted). These same authorities advised segregating persons with disabilities from the rest of society—not only to minimize the "menace" they posed, but ostensibly because they themselves would benefit from segregation. See, e.g., Yoakum, *Care of the Feebleminded in Texas*, in BULLETIN OF THE UNIV. OF TEX. 83 (Nov. 5, 1914) (segregating persons with disabilities described as "consistent with a deep and abiding charity [that] . . . permits all to live under those circumstances best suited to make each useful and happy").

States heeded the call to segregate persons with disabilities from their communities. One author recounted

the nearly universal state segregation of persons with disabilities which existed throughout this country. That policy of segregation, implemented through official state action, legislatively deemed persons with disabilities to be "unfit for citizenship." In virtually every state, in inexorable fashion, people with disabilities—especially children and youth—were declared by state lawmaking bodies to be "unfitted for companionship with other children," a "blight on mankind" whose very presence in the community was "detrimental to normal" children, and whose "mingling . . . with society" was "a most baneful evil."

Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 TEMPLE L. REV. 393, 400-401 (1991) (footnotes omitted). Another author concluded that to these impositions the states "added some disgraceful refinements: compulsory eugenic sterilization laws, wholesale exclusion from schooling; and a total restriction on rights amounting to a virtual civil death." STANLEY S. HERR, RIGHTS AND ADVOCACY FOR RETARDED PEOPLE 28 (1983). As a result, Justice Marshall noted,

[a] regime of state-mandated segregation and degradation soon emerged that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow. Massive custodial institutions were built to warehouse the retarded for life; the aim was to halt reproduction of the retarded and "nearly extinguish their race."

*City of Cleburne*, 473 U.S. at 462 (Marshall, J., concurring in part and dissenting in part) (citations omitted).

Justice Marshall did not exaggerate the parallel between racial segregation and discrimination against citizens with mental retardation, for the justifications offered for the latter mimicked those of the former. Cf., e.g., *Plessy v. Ferguson*, 163 U.S. 537, 551-552 (1896). Isolation of persons with mental illness or mental retardation was justified on the basis that they were not worthy to interact with society at large, but were by nature inferior—and segregation in any event was said to have its good points. The edifice of racial segregation began to crumble with *Brown v. Board of Education*, 347 U.S. 483 (1954), however, and over the decades that followed, professionals and policymakers alike began to recognize that the segregation and institutionalization of persons with disabilities also offended fundamental notions of decency. See, e.g., Arlene S. Kanter, *A Home of One's Own: The Fair Housing Amendments Act of 1988 and Housing Discrimination Against People with Mental Disabilities*, 43 AM. U. L. REV. 925, 929 (1994); American Ass'n on Mental Retardation, *Position Statement on Least Restrictive Alternatives in Living Arrangements* (June 1977).

As the professional community and governmental bodies turned away from the practice of segregation, an emerging body of literature began to support a policy of "normalization." The normalization principle holds that persons with disabilities do better when they live among, rather than apart from, the rest of society. Literature began to recognize the injuries that resulted from the unnecessary isolation of persons with disabilities from "the normal rhythm of daily routines of occupation, leisure, and personal life." Bengt Nirje, *The Normalization Principle and its Human Management Implications*, in PRESIDENT'S COMM. ON MENTAL RETARDATION, *CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED* 179, 186-187 (R. Kugel & W. Wolfensberger eds., 1969).

Congress was acutely aware of this history of official segregation of persons with disabilities and the ensuing turn towards the principle of normalization. Indeed, Congress expressly described the ADA as an attempt to eliminate the lingering effects of this

historical legacy of segregation, which had persisted despite previous remedial efforts:

[H]istorically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem[.]

42 U.S.C. § 12101(a)(2). This historical background illuminated the ADA's finding that "discrimination against individuals with disabilities persists in . . . institutionalization," among other areas. *Id.* § 12101(a)(3). Congress also found that "individuals with disabilities continually encounter various forms of discrimination, including . . . segregation" as a consequence of their disability. *Id.* § 12101(a)(5). It declared that "the Nation's proper goals regarding individuals with disabilities" included "assur[ing] . . . independent living . . . for such individuals." *Id.* § 12101(a)(8).

Although resort to legislative history might be deemed unnecessary in the face of such clear statutory text, it bears noting that the legislative record powerfully confirms Congress' awareness of the legacy of segregation of individuals with disabilities and the legislative intention to end the practice. For example, the ADA's finding that discrimination persists in institutionalization comes directly from a 1983 report by the United States Commission on Civil Rights entitled *Accommodating the Spectrum of Individual Abilities*, on which the Senate report accompanying the ADA heavily relied.<sup>3</sup> See United States Comm'n on Civil Rights, Clearinghouse Pub. No. 81, *Accommodating the Spectrum of Individual Abilities* (Sept. 1983) ("*Accommodating the Spectrum*").

The *Accommodating the Spectrum* report on which Congress relied emphasized that forced institutionalization was a form of

<sup>3</sup> The Senate report noted that "[h]istorically, individuals with disabilities have been isolated and subjected to discrimination and such isolation and discrimination is still pervasive in our society." S. Rep. No. 116, 101st Cong., 1st Sess. 6 (Aug. 30, 1989) (quoting *Accommodating the Spectrum* 159). It found that "[d]espite some improvements, . . . [discrimination] persists in such critical areas as . . . institutionalization[.]" S. Rep. No. 116, at 8 (quoting *Accommodating the Spectrum* 159).



discrimination against persons with disabilities. In a section captioned "Forms of Discrimination," the report explained that "[s]egregation singles out handicapped people and separates them from the rest of society, frequently as a condition for receiving some service or benefit." *Accommodating the Spectrum* 41. After summarizing several respects in which persons with disabilities are segregated, the report notes that "[m]ental health and mental retardation institutions that house residents in almost complete isolation from the non-handicapped community are perhaps archetypal examples of segregation." *Id.* The evidence on which Congress expressly relied in passing the ADA thus made clear that the segregation of persons with disabilities from the broader community, including through needless institutionalization, was a form of discrimination the ADA was meant to address.

By pursuing policies that essentially called for institutionalization as the treatment option of first resort, even for persons with minor disabilities, states swelled the ranks of individuals unnecessarily segregated and isolated from their families and communities. By restricting per capita expenditures on state institutions, more residents could be admitted on a limited state budget which, as the Civil Rights Commission's report noted, "fostered large, understaffed institutions often providing minimal custodial services to residents." *Accommodating the Spectrum* 20 (footnote omitted). As discussed in the next section, however, the "minimal custodial services" offered by overcrowded state institutions did little to alleviate, and much to exacerbate, the developmental and other problems of those whom the institutions ostensibly existed to serve.

#### **B. Community Living Benefits Persons Who Have Mental Disabilities; Unnecessary Institutionalization Harms Them**

Congress' requirement that states place persons with disabilities into the most integrated setting appropriate in which they could interact with nondisabled persons was soundly based in the professional literature. The experience of *amici* and a substantial supporting body of professional literature strongly show that per-

sons such as the plaintiffs below<sup>4</sup> benefit far more from placement in community-living arrangements than from being forced to remain in an institution. Congress was well aware at the time it enacted the ADA that persons with disabilities can be far more effectively served in a community environment.

Persons with disabilities derive proven benefits from community living. Among these are increased independence and a sense of competence; improved relationships with family members and friends; and increased respect, dignity, and feelings of being a part of community life. See Barbara Wright & Martha P. King, National Conference of State Legislatures, *Americans with Developmental Disabilities: Policy Directions for the States* 21 (Feb. 1991). Individuals with disabilities who are placed in community settings can develop fuller, more enjoyable lives in ways nondisabled persons take for granted, but which are essentially impossible to achieve in an institution—they attend movies, go shopping, enjoy parks and recreation, and visit friends. See Cook, *supra*, at 450 n.385 and authorities cited. Justice Marshall noted just such concerns in writing that isolating persons with mental retardation from the community "deprives [them] of much of what makes for human freedom and fulfillment—the ability to form bonds and take part in the life of the community." *City of Cleburne*, 473 U.S. at 461 & n.5 (Marshall, J., concurring in part and dissenting in part).

The professional literature overwhelmingly confirms that people with mental disabilities who reside in a variety of community settings experience improved adaptive behavior, improved social participation, improved independence, improved control over decision making, and improved perceived quality of life.<sup>5</sup> For exam-

<sup>4</sup> It is undisputed that for the plaintiffs below, L.C. and E.W., the most appropriate placement was in the community. This case concerns only the state's claimed entitlement to institutionalize *unnecessarily* persons for whom such confinement is not required. The courts below did not hold that the ADA requires states to serve in the community particular individuals for whom such an environment would be inappropriate. (See Pet. App. 21a).

<sup>5</sup> See, e.g., James W. Conroy, *Results of Deinstitutionalization in Connecticut, in* DEINSTITUTIONALIZATION AND COMMUNITY LIVING (Jim Mansell & Kent Ericsson eds., 1996); James W. Conroy, *The Hissom Outcomes Study: A Report of*

*Six Years of Movement to Supported Living* (Dec. 1995) (persons with mental retardation and developmental disabilities who had been deinstitutionalized and placed in small community settings showed significant increases in adaptive behavior, productivity, employment, family contact, and overall quality of life); Teh-wei Hu & Jaclyn W. Hausman, Institute for Mental Health Services Research Working Paper No. 4-94, *Cost-Effectiveness of Community Based Care for Individuals with Mental Health Problems* 26 (July 1994) (community treatment credited with "reduced long-term inpatient hospitalization and readmission rates"; individuals with psychiatric disabilities in "the community based program had higher self-report[ed] satisfaction of life, and improvement of quality of life"); James W. Conroy, et al., Connecticut Dep't of Mental Retardation Report No. 10, *1990 Results of the CARC v. Thorne Longitudinal Study* 40-43, 55, 66 (Jan. 1991) (persons moving from large congregate setting to small community setting showed increase in adaptive behavior, social interaction, valued employment, quality of life, and family satisfaction); John Lord & Alison Pedlar, *Life in the Community: Four Years After the Closure of an Institution*, 29 MENTAL RETARDATION 213, 219 (1991) (four years after eighteen people were moved from institutional setting to community integrated group home, virtually all had progressed in skills development, and family members reported that their relative was generally happier and responding positively to the stimulation of community living); Paul J. Carling, *Major Mental Illness, Housing, and Supports*, 45 AM. PSYCHOLOGIST 969, 971 (Aug. 1990) (citing Charles A. Kiesler, *Mental Hospitals and Alternative Care: Noninstitutionalization as Potential Public Policy for Mental Patients*, 37 AM. PSYCHOLOGIST 349, 349-360 (1982); Peter Braun et al., *Overview: Deinstitutionalization of Psychiatric Patients—A Critical Review of Outcome Studies*, 138 AM. J. PSYCHIATRY 736, 736-749 (1981); Donald J. Delario & William A. Anthony, *On the Relative Effectiveness of Institutional and Alternative Placements of the Psychiatrically Disabled*, 37 J. SOC. ISSUES 21, 21-33 (1981)); Francine Cournos, *The Impact of Environmental Factors on Outcome in Residential Programs*, 38 HOSP. & COMM. PSYCH. 848, 849 (Aug. 1987) (community living provides a critical alternative to hospital-based care, and even to family care by relatives, especially for persons with severe mental disabilities who require assisted living); James W. Conroy & Valerie J. Bradley, Temple University Developmental Disabilities Center, Philadelphia & Human Services Research Institute, Boston, *The Pennhurst Longitudinal Study: A Report of Five Years of Research and Analysis* (Mar. 1985) (persons with severe mental retardation placed from an institution into small community living arrangements showed significant increase in adaptive behavior, marked decrease in dependency, and significant increase in happiness in most aspects of their lives); James Conroy, Joelle Efthimiou, and James Lemanowicz, *A Matched Comparison of the Developmental Growth of Institutionalized and Deinstitutionalized Mentally Retarded Clients*, 86 AM. J. MENTAL DEFICIENCY 581 (1982) (individuals who left state institution for community placement showed significantly improved functioning and adaptive behavior after two years in the community); B.K. Hill & R.H. Bru-

ple, a survey of eighteen studies conducted between 1976 and 1988 found that every one reported positive gains in the development of functional skills and adaptive behavior for persons moving from an institutional to a community setting. Sheryl Larson & Charlie Lakin, University of Minnesota Institute on Community Integration, *Deinstitutionalization of Persons with Mental Retardation: The Impact on Daily Living Skills* (Mar. 1989). Studies also overwhelmingly show that community-based treatment is more effective than hospital-based care in helping people with mental illness become employed, re-enter the community, and reduce the use of medication. See Paul J. Carling, *Major Mental Illness, Housing, and Supports*, 45 AM. PSYCH. 969, 971 (Aug. 1990) and authorities cited. Evidence also suggests that institutional settings adversely affect residents' motor-learning skills, communications skills, and general social competency.<sup>6</sup>

In deploying the ADA against "institutionalization" and "segregation" and in favor of "independent living," 42 U.S.C. § 12101(a)(3), (5), (8), Congress has recognized the substantial benefits of community living, whether measured by scientific surveys or by simple expressions of happiness. Although needs may differ from one individual to another, the core concept of establishing a home in a neighborhood where residents can live what society perceives as a "normal" everyday life, has proved successful time and again.

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ininks, University of Minnesota Center for Residential and Community Services, *Family Leisure and Social Activities of Mentally Retarded People in Residential Facilities* (1981) (for persons with all levels of mental retardation, moving to a community setting results in improved adaptive behavior and increased social participation). See also Cook, *supra*, at 455-456 nn.408-416 and authorities cited.

<sup>6</sup> See, e.g., Daniel Lauber, *Report on Houston's Interim Regulatory and Zoning Ordinance Proposals for Group Homes, Halfway Houses, Hospices, Emergency Shelters, and Social Service Facilities* 6 (Aug. 18, 1992) (citing Jerri L. Phillips & Earl E. Balthazar, *Some Correlates of Language Deterioration in Severely and Profoundly Retarded Long-Term Institutionalized Residents*, 83 AM. J. MENTAL DEFICIENCY 402-408 (1979)).



## II. THE ADA REPRESENTS THE CULMINATION OF FEDERAL POLICY FOSTERING COMMUNITY-BASED SERVICES FOR PERSONS WITH DISABILITIES

The enactment of the ADA and the promulgation of the Integration Regulation<sup>7</sup> represented a significant reinforcement of federal rights for the community integration of persons with disabilities. Congress previously enacted measures that embraced the policy of normalization and recognized the need to end the lingering harms caused by continued segregation of persons with disabilities from their communities. The ADA's mandate for integration represents the culmination of Congress' efforts to secure the opportunity and benefits of community living for people with disabilities.

Congress took an early step in promoting integration with the Mental Retardation Facilities and Community Mental Health Centers Construction Act ("Construction Act"), Pub. L. No. 88-164, 77 Stat. 282 (1963),<sup>8</sup> which provided federal funding for mental disability services in the community.

In the Developmental Disabilities Assistance and Bill of Rights Act, Congress specifically declared that "[t]he treatment services, and habilitation for a person with developmental disabilities should be . . . provided in the setting that is least restric-

<sup>7</sup> The Department of Justice's regulations setting forth the prohibited forms of discrimination have been found to be "entitled to substantial deference" by the courts. *Helen L. v. DiDario*, 46 F.3d 325, 331-332 (3d Cir. 1995).

<sup>8</sup> This statute was repealed and superseded in 1981 by a provision of the Omnibus Budget Reconciliation Act, Pub. L. No. 97-35, § 902(e)(2)(B), 95 Stat. 357, 560 (1981). The 1981 Act amended the federal Medicaid program to allow States to apply for a waiver of certain Medicaid requirements in order to offer home- and community-based services, in lieu of institutionalization, for people with mental disabilities. See Pub. L. No. 97-35, §§ 2176, 2177(a), 95 Stat. at 812-813 (codified at 42 U.S.C. § 1396n(c)); see also 42 U.S.C. § 1397(4) (creating federal block grants aimed in part at "preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care").

tive of the person's personal liberty." Pub. L. No. 94-103, 89 Stat. 486, 502 (1975). The accompanying House Report declared that "for the vast majority of individuals institutional care is inappropriate and inhumane." H.R. Rep. No. 94-58, at 15, reprinted in 1975 U.S.C.C.A.N. 919, 933. Congress later amended the Act to assert even more forcefully the "national interest" of promoting the right and opportunity for people with developmental disabilities to be part of the community, "to make decisions for themselves and to live in typical homes and communities where they can exercise their full rights and responsibilities as citizens." 42 U.S.C. § 6000(a)(4), (9) (emphasis added). Congress also stressed its goal "to promote the inclusion of all persons with developmental disabilities, including persons with the most severe disabilities, in community life." 42 U.S.C. § 6000(b)(5).

Congress did not stop with efforts to provide community treatment options for persons with disabilities. It took additional steps to ensure that communities did not, by virtue of entrenched negative stereotypes of persons with disabilities, undermine opportunities for community living. The first such effort was the Rehabilitation Act of 1973, 29 U.S.C. §§ 701-797b. The Act aimed to "develop and implement . . . comprehensive and coordinated programs of vocational rehabilitation and independent living, for individuals with handicaps in order to maximize their . . . integration into the workplace and the community." 29 U.S.C. § 701. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, outlawed discrimination against persons with disabilities by any recipient of federal assistance.<sup>9</sup> This Court has previously passed on the meaning and importance of section 504. See *Alexander v. Choate*, 469 U.S. 287, 297 (1985) (section 504 outlaws both intentional and unintentional discrimination); *School Board v. Arline*, 480 U.S. 273, 279 (1987) (in enacting section 504 Congress was con-

<sup>9</sup> The pertinent portions of Section 504 then provided that:

No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance[.]

29 U.S.C. § 794.

cerned with "protecting the handicapped against discrimination stemming not only from simple prejudice, but also from 'archaic attitudes and laws' and from 'the fact that the American people are simply unfamiliar with and insensitive to the difficulties confront[ing] individuals with handicaps.'" (citation omitted).

In the ADA, Congress took strong steps to clarify and extend the application of section 504 of the Rehabilitation Act, including making a specific set of findings and standards for interpretation in 42 U.S.C. § 12101. Congress stated—not in legislative history, but directly in the text of the statute itself—its intention "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities" including "segregation." 42 U.S.C. § 12101(b)(1), (a)(5).

Support for the ADA was overwhelming, transcending party affiliation, regional differences, and intergovernmental rivalries. The measure's sponsors forged a near-unanimous consensus behind the fundamental objective of integrating persons with disabilities into mainstream American life. The legislation passed both Houses of Congress by vast margins.<sup>10</sup> Then-Attorney General Richard Thornburgh, testifying before the Senate on the legislation that became the ADA, lamented that "[f]ifteen years have gone by since the Rehabilitation Act took effect. Nonetheless, persons with disabilities are still too often shut out of the economic and social mainstream of American life." *Americans With Disabilities Act of 1989: Hearings on S. 933 Before the Senate Comm. on Labor and Human Resources and the Subcomm. on the Handicapped*, 101st Cong., 1st Sess. 195 (1989). In signing the ADA, President Bush remarked with sadness on the historical legacy the Act was intended to overcome, noting that despite previous civil rights legislation, "the stark fact remained that people with disabilities were still victims of segregation and discrimination, and this was intolerable." *Remarks on Signing the Americans with Disabilities Act of 1990*, 1990 PUB. PAPERS 1067, 1068 (July 26, 1990). The ADA, President Bush explained, would "ensure that

<sup>10</sup> The final conference report on the ADA was adopted by a vote of 377-28 in the House and 91-6 in the Senate. The original bills passed in the House by 403-20 and in the Senate by 76-8. See 1990 CONG. QTRLY. ALMANAC 447.

people with disabilities are given the basic guarantees . . . [of] independence, freedom of choice, control of their lives, the opportunity to blend fully and equally into the rich mosaic of the American mainstream." *Ibid.* In a forceful declaration of the ADA's purpose to end needless segregation, President Bush concluded with a clear statement of federal policy: "Let the shameful wall of exclusion finally come tumbling down." *Id.* at 1070.

Doubtless due in part to the lingering force of what Justice Marshall identified as "[a] regime of state-mandated segregation and degradation" of persons with mental disabilities, the ADA expressly extended to all state and local governments the non-discrimination principles of section 504 of the Rehabilitation Act. See 42 U.S.C. §§ 12131(1), 12132. Although the statutory text of section 504 had been silent on the question whether segregation of persons with disabilities was permissible,<sup>11</sup> Congress in the ADA spoke with singular clarity, repeatedly expressing in statutory findings that needless segregation of persons with disabilities is a "form[] of discrimination" Congress wished to eliminate. 42 U.S.C. § 12101(a)(5); see also 42 U.S.C. § 12101(a)(2), (3).

The common thread linking the anti-discrimination statutes from the Construction Act, through the Rehabilitation Act, to the Americans with Disabilities Act, has been ever-increasing antipathy for the legacy of segregation and discrimination borne by persons with disabilities, matched by ever-stronger legislation in favor of integration of such individuals into the community. The decision of the court of appeals represents the only interpretation

<sup>11</sup> The regulations implementing Section 504, though, defined segregation of persons with disabilities as unlawful when services were not provided "in the most integrated setting appropriate to the person's needs." 45 C.F.R. § 84.4(b)(2). Although the statutory text did not explicitly so state, the consistent position of the Department of Justice during the Carter and Reagan Administrations was that unnecessary segregation was a prima facie violation of Section 504. See Brief for the United States at 39-45, *Halderman v. Pennhurst State Sch. & Hosp.*, 612 F.2d 84 (3d Cir. 1979) (Nos. 78-1490 et al.); Supplemental Brief for the United States at 2-10, *Halderman v. Pennhurst State Sch. & Hosp.*, 612 F.2d 84 (3d Cir. 1979) (Nos. 78-1490 et al.); Brief for the United States at 27, *Halderman v. Pennhurst State Sch. & Hosp.*, 673 F.2d 647 (3d Cir. 1982) (Nos. 78-1490 et al.). See generally the Brief of Amicus Curiae Dick Thornburgh and the National Organization on Disability in Support of Respondents, submitted in this case.



of the ADA consistent with its statutory history. Petitioners and their *amici* are fundamentally attacking the federal policy favoring integration over segregation. But Congress, not the court of appeals, is the author of that policy—and Congress is the body to which Petitioners' arguments should be directed.

### III.

#### AFFIRMING THE JUDGMENT BELOW POSES NO RISK OF DISRUPTING STATE PROGRAMS OR BUDGETS

Petitioners and their supporting *amici* raise a specter of mass disruption of state programs they contend will arise if the court of appeals' judgment stands. Undersigned *amici* submit that this supposed risk is more speculative than real. The current policy commitment of the states to community services for persons with disabilities undercuts Petitioners' argument that integrated community treatment will disrupt state programs, and the demonstrable cost savings resulting from community services suggest that Petitioners' fears of budget overruns are ill-founded.

#### A. Most States Have Already Committed Themselves to an Official Policy of Community Treatment and Habilitation

The official policies established by state mental health and mental retardation agencies establish a strong state preference to serve individuals with disabilities in community, rather than institutional, settings. Thus, for example, as Petitioners concede (Pet. Br. 5), most states have taken the official position that persons with mental disabilities must be treated in the "least restrictive" environment appropriate to their needs. See, e.g., Ga. Comp. R. & Regs. r. 290-4-9-.02(1)(a).<sup>12</sup>

<sup>12</sup> See also Alaska Stat. § 47.30.655(2) (1998); Cal. Welf. & Inst. Code § 5325.1(a) (1999); Colo. Rev. Stat. §§ 27-10-101, 27-10-116(1)(a) (1997); Conn. Gen. Stat. § 17a-274(a) (1997); D.C. Code Ann. §§ 6-1901(a)(2), 6-1963 (1998); Haw. Rev. Stat. §§ 333F-8(a)(1), (2), 334-104 (1998); Ill. Ann. Stat. ch. 405, para. 5/2-102(a) (Smith-Hurd 1997); Iowa Code § 225C.28A(5) (1997); Kan. Stat. Ann. § 39-1603(g), (i) (1997); La. Rev. Stat. Ann. §§ 28:50(2), 28:390(B) (1998); Me. Rev. Stat. Ann. tit. 34-B, § 3003(2)(A) (1997); Md. Code

Petitioners' home state of Georgia has officially undertaken "to provide community-based alternatives to total institutional care so that mentally retarded individuals can continue to live in their home communities." Ga. Code Ann. § 37-5-2 (1982); see also Ga. Code Ann. § 37-2-1 (Supp. 1994). Indeed, many other states have endorsed community-based care in express terms—including several of the states whose *amicus curiae* brief incorrectly argues that such treatment would work a fundamental alteration in their programs. Significantly, many of the states that originally supported the petition for certiorari have since abandoned Petitioners' cause, reflecting the recognition that reversal of the judgment below poses a far greater threat to settled state policy than does affirmation. Twelve states—Alabama, California, Delaware, Florida, Maryland, Michigan,<sup>13</sup> Nebraska, New Hampshire, Pennsylvania, South Dakota, Utah, and West Virginia—and also the Territory of Guam, did not join the states' *amicus curiae* brief on the merits stage of this proceeding after having joined the *amicus* brief in support of the petition for certiorari. Furthermore, several addi-

Ann., Health-Gen. § 7-502(c) (1998); Mich. Comp. Laws § 330.1521 (1998); Minn. Stat. § 245.467(1)(3) (1998); Mo. Rev. Stat. § 630.115(1)(11) (1997); Mont. Code Ann. § 53-20-148(2) (1998); Neb. Rev. Stat. § 71-5053 (1998); N.H. Rev. Stat. Ann. §§ 126-A:19, 135-C:1(II)(b) (1998); N.J. Rev. Stat. § 30:4-24.2(e)(2) (1998); N.M. Stat. Ann. § 43-1-9(C)(2) (1998); N.Y. Comp. Codes R. & Regs. tit. 14, § 586.1(b) (1998); N.C. Gen. Stat. § 122C-2 (1997); N.D. Cent. Code § 21-01.2-02 (1998); Ohio Rev. Code Ann. §§ 340.011(A)(2), 5119.47 (1998); Okla. Stat. tit. 43A, § 1-104 (1998); Or. Rev. Stat. § 410.720(1) (1997); R.I. Gen. Laws §§ 40.1-5.4-6(2), 40.1-8.5-1(a) (1998); S.C. Code Ann. § 44-20-20 (1998); Wash. Rev. Code Ann. § 71.24.015 (1998); cf. Ark. Code Ann. § 20-47-201(b)(2) (1997) (care of persons with mental illness should be "[l]east restrictive of the person's freedom of movement and ability to function normally in society").

<sup>13</sup> In a telling repudiation of Petitioners' position, the State of Michigan explained its withdrawal by saying that, after taking "a fresh look at the arguments Georgia is making," it had concluded that "Georgia's arguments are not consistent with the State of Michigan's position as a leader in community-based mental health care, so we will not join the *amicus* brief." Letter from Thomas L. Casey, Solicitor General of Michigan, to Elmer L. Cerano, Executive Director, United Cerebral Palsy Association of Metropolitan Detroit, Inc., Feb. 3, 1999, at 1.

tional states—Minnesota, Louisiana,<sup>14</sup> Massachusetts,<sup>15</sup> and Washington—have taken the highly revealing step of disavowing the states' amicus brief on the merits, which they had originally joined at the time of filing.

The small minority of states that continue to support the Petitioners do so even though many of their own state statutes take a contrary position. A few examples are instructive. The State of Montana, a signatory to the states' amicus brief in support of Petitioners, has a statutory directive requiring the state to "make every attempt to move residents" of state institutions "from . . . segregated from the community to integrated into the community living." Mont. Code Ann. § 53-20-148(2)(e) (1998). Hawaii, another signatory, contradicts its own policy that favors "alternatives to institutional care . . . based on principles of residential, community-based treatment," and which guarantees persons with disabilities the rights to "[i]nteract with persons without disabilities in a non-treatment, nonservice-oriented setting," to "[l]ive with, or in close proximity to, persons without disabilities," and to "[l]ive in a setting which closely approximates those conditions available to persons without disabilities of the same age." Haw. Rev. Stat. §§ 333F-8(a)(3), 334-101 (1998). South Carolina joined the states' amicus brief even though its own laws establish a policy of "providing services to enable [persons with mental retardation and related disabilities] to participate as valued members of their communities to the maximum extent practical and to live with their families or in family settings in the community[.]" S.C. Code Ann. § 44-20-20 (1998). Many other states that do not support the Petitioners have legislation furthering the policies articulated by the

<sup>14</sup> See Letter from Laura Bracklin, Executive Director, Office of Disability Affairs, Office of the Governor of Louisiana, to Ira Burnim, Bazelon Center for Mental Health Law, Mar. 11, 1999, at 1.

<sup>15</sup> The Attorney General of Massachusetts explained that its earlier participation in the amicus brief "has been wrongly interpreted as a retreat by the Commonwealth from its long-standing support of disability rights in general and deinstitutionalization in particular." Letter from Tom Reilly, Attorney General of Massachusetts, to William D. O'Leary, Secretary of the Massachusetts Executive Office of Health and Human Services, Mar. 5, 1999, at 1.

Respondents in this case.<sup>16</sup> Indeed, although sounding a cautionary note about rising demand, the governor of New York recently trumpeted his state's "overwhelming success in changing from an

<sup>16</sup> See, e.g., Cal. Welf. & Inst. Code § 5325.1(g) (1999) (guaranteeing persons with disabilities "[a] right to social interaction and participation in community activities"); D.C. Code § 6-1901(a)(5) (1998) (establishing legislative objective to "[m]aximize the assimilation of mentally retarded persons into the ordinary life of the community in which they live"), (b)(2) ("[t]he use of institutionalization shall be abated to the greatest extent possible"), (4) ("[i]ndividuals placed in institutions shall be transferred to community or home environments wherever possible, consistent with professional diagnoses and recommendations"); Kan. Stat. Ann. § 39-1603(f) (1997) (declaring state policy to be "to assist in the provision of services for persons who are mentally ill in local communities whenever possible"); N.H. Rev. Stat. Ann. §§ 126-A:19 (1998) (state policy is to establish "community living facilities for persons with developmental disabilities or mental illness"), 135-C:1(II)(a) (state policy is to provide "persons who are severely mentally disabled adequate and humane care . . . [w]ithin each person's own community"); Ohio Rev. Code Ann. § 340.011(A)(2), (5) (1998) (state policy to "[e]stablish a community support system" providing "comprehensive community mental health services"); Or. Rev. Stat. § 427.007 (1997) (state aims "to facilitate the development of appropriate community-based services"); R.I. Gen. Laws § 40.1-5.4-5(1) (state policy is to "provide persons with serious mental illness adequate and humane care . . . [w]ithin each person's own community . . ."); Wash. Rev. Code Ann. § 71.05.010(6) (state's policy is "whenever appropriate, that services [to persons with mental disabilities] be provided *within the community*") (emphasis added).

Even apart from the applicable statutory provisions, many state agencies have publicly declared their objectives to be to maximize the treatment of individuals with disabilities in community, rather than institutional, settings. For example, the Mission Statement of the Colorado Mental Health System declares that "[a]ll persons with mental illnesses . . . should receive treatment in community-based, community-integrated programs delivered in the least restrictive environment possible." Colorado Department of Human Services, *Mental Health Services: Mission Statement and Values* (last modified Dec. 2, 1998) <<http://www.cdhs.state.co.us/ohr/mhs/mission.html>>. See also New Jersey Department of Human Services, Division of Mental Health Services, *Mission Statement* (visited Feb. 12, 1999) <<http://www.state.nj.us/humanservices/MHSDiv.html#Mission>> ("The mission of the mental health system in New Jersey is to promote opportunities for persons with serious mental illness to maximize their ability to live, work, socialize, and learn in communities of their choice").



institutionally-based system, . . . to a community-based system that now serves nearly 31,000 citizens in the community[.]”<sup>17</sup>

The states’ broad policy agreement in favor of community care for persons with mental disabilities reflects the virtually unanimous consensus of expert opinion described in the preceding section. Indeed, as Professor David Braddock and his colleagues conclude, the movement “toward family support and community living, and away from the segregated institutional model of the 19th century” is now the dominant trend. DAVID BRADDOCK ET AL., AM. ASS’N ON MENTAL RETARDATION, *THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES* 16 (5th ed. 1998). Unnecessary institutionalization is already a derogation of established state policies and the settled expectations of treating professionals. Affirmance of the court of appeals’ decision would represent fidelity to, not the upsetting of, the philosophies that have long since come to govern state programs for persons with mental disabilities. Indeed, reversal would undermine the broad-based state policies supporting community-based care.

The states have compiled mixed records, however, in effectuating the principles of community integration. The resulting gap between rhetoric and performance makes judicial enforcement of the ADA and the Integration Regulation all the more appropriate. For instance, although Petitioners’ home state of Georgia has committed itself, at least on paper, to a regime of community-based care for persons with mental retardation and other mental disabilities,<sup>18</sup> its performance in this regard has significantly trailed that of other states.

Nationally, Georgia ranks among the states with the worst records of segregating persons with mental disabilities. Despite the federal and state policies in favor of community treatment, the state of Georgia trails badly in implementing these principles. See BRADDOCK ET AL., *supra*, at 173 (Georgia in 1996 ranked 50th out of the 50 states plus the District of Columbia in the number of

<sup>17</sup> New York State Office of Mental Retardation and Developmental Disabilities, *Governor Announces ‘NYS-Cares’ to Reduce Housing Waiting List* (last modified Aug. 19, 1998) <<http://www.omr.state.ny.us/nycares.htm>>.

<sup>18</sup> See, e.g., Ga. Code Ann. §§ 37-2-1, 37-5-2 (1998).

people served in community residential settings on a per capita basis, and had “the ninth highest percentage of total residential placements in congregate facilities”); Robert Prouty & K. Charlie Lakin, Univ. of Minn. College of Educ., *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1995*, at 51, 53 (May 1996) (Georgia ranked next-to-last in the nation in average rate of placement for persons with mental retardation and related disabilities in residential settings with 15 or fewer residents).

In 1992, Georgia applied to the federal government for a Medicaid waiver (under 42 U.S.C. § 1396n(c)) to provide home- and community-based services to persons with mental retardation. Describing its application as “a major initiative to decrease the use of institutions and to increase the likelihood of individuals with intense needs remaining at home or in other community settings,” the state declared that:

Over the next five years, the Department is committed to downsizing the ICF/MR [Intermediate Care Facility for the Mentally Retarded] population to less than half its current size. . . . To achieve this goal, 200 individuals per year will be placed in community services rather than continuing in ICF/MR services.

Georgia Department of Medical Assistance, *Request to Provide Home and Community-Based Services Under Section 1915(c) of the Social Security Act for the Purpose of Serving Persons with Mental Retardation* ii–iii (Apr. 1992–Mar. 1997). Although committing itself in its waiver application to a goal of placing 1,000 individuals in community-based settings over a five-year period, a November 1996 report on the state’s Brook Run institution noted that the state’s performance had fallen far short of the mark:

An obligation to reduce institutional beds by 1,000 by 1997 was established in the 1992 Renewal of the Home and Community Based Services Waiver for Mental Retardation. As of September 1996, only 147 of the proposed 1,000 bed reduction has been realized. The limited success has been due primarily to not having identified a concentrated closure of a large

enough number of institutional beds needed to generate the necessary savings.

*Evaluation of Brook Run, A State Mental Retardation Institution: A Report Prepared by a Special Task Force Appointed by the Privatization Commission 8* (Nov. 1996) ("Evaluation of Brook Run").

#### B. Community Care Costs Less Than Institutionalization

Petitioners and their supporting *amici* also raise the specter of ballooning expenditures if the judgment of the court of appeals is affirmed.<sup>19</sup> A closer look, however, reveals this argument to be a red herring. The evidence suggests that providing services in a community setting is less costly per capita than similar treatment provided in a state institution. (See Pet. App. 39a & n.4). It is the perpetuation of the legacy of over-institutionalization, not the modern trend toward community treatment, that poses the greater threat to state mental health budgets. Upholding the decision of the court of appeals, far from representing an undue interference in state spending decisions, will merely reaffirm the sensible principle that states ought not choose the most expensive alternative—institutionalization—where the cheaper option of community treatment will be as or more effective.

Data from the State of Georgia itself show the greater public expense involved in forcing persons like plaintiffs L.C. and E.W. to undergo treatment in costly state institutions. The figures for the

<sup>19</sup> Petitioners have raised the issue of cost as an argument for rejecting the statutory interpretation adopted by the courts below. Although their view is wrong on the merits, it is not strictly necessary for this Court to address the issue of costs in any event. Where Congress has not made cost a relevant consideration in the statutory scheme, as in the ADA, the courts should ordinarily show great reluctance to graft a cost-based inquiry onto the statutory structure. See *Cedar Rapids Comm. Sch. Dist. v. Garret F.*, — U.S. —, 1999 WL 104410, at \*6 (U.S. Mar. 3, 1999) ("Given that § 1401(a)(17) [of the Individuals with Disabilities Education Act (IDEA)] does not employ cost in its definition of 'related services' or excluded 'medical services,' accepting the District's cost-based standard as the sole test for determining the scope of the provision would require us to engage in judicial lawmaking without any guidance from Congress. It would also create some tension with the purposes of the IDEA.").

Georgia Regional Hospital—Atlanta ("GRH-A"), the state psychiatric hospital where both L.C. and E.W. were once housed, are illuminating. The per diem, per capita cost of institutional care at the special unit for persons with mental retardation at GRH-A was \$283 in fiscal 1996, for an annual cost of \$103,295. (JA 93). For all adult psychiatric services at GRH-A, the cost per person ranges from \$219 to \$505 per diem, or an annual total of \$79,935 to \$184,325. (*Ibid.*). In contrast, under Georgia's Medicaid waiver program, the per diem cost for community services per person is approximately \$118 to \$124, for an annual total cost of \$43,070 to \$45,260. (*Ibid.*).<sup>20</sup>

For fiscal year 1997, a recent study found that "[t]he average annual Medicaid expenditures for ICF-MR [Intermediate Care Facilities for Persons with Mental Retardation] services were \$78,899 per person as compared to \$26,729 for each HCBS [Medicaid Home and Community Based Services] recipient." R.W. Prouty & K.C. Lakin, Institute on Community Integration/Research and Training Center on Community Living, University of Minnesota College of Education and Human Development, Report No. 51, *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 1997*, at xiii (May 1998).<sup>21</sup>

In *Helen L. v. DiDario*, 46 F.3d 325 (3d Cir. 1995), another court of appeals assessed the evidence regarding the relative costs of treating individuals with disabilities in a publicly funded institution (there, a nursing home) versus treatment in the individual's own home (through a state-funded attendant care program). The court gave the following summary of the evidence:

<sup>20</sup> The State of Georgia expected significant cost savings to result from the closure of its Brook Run institution—savings sufficient to "provide community services to 532 individuals," a figure greater than "the current 326 residents of Brook Run[.]" *Evaluation of Brook Run*, *supra*, at 17.

<sup>21</sup> These are average national statistics. For the State of Georgia, the corresponding figures for fiscal 1997 are as follows. Medicaid ICF-MR expenditures per end of year resident: \$71,923; Medicaid HCBS expenditures per end of year recipient, \$27,071. See *id.* at 81, 87 tbls. 3.4, 3.7. An ICF-MR is a state institution that provides care for persons with mental retardation.



DPW's average cost of caring for a person in a nursing home is \$45,000 per year. The Commonwealth pays 44% of this amount (\$19,800) and the difference (\$24,200) is paid by the federal government. DPW's average cost of caring for a person in the attendant care program is \$10,500 per year. That amount is totally borne by the Commonwealth.

*Id.* at 329. Idell S., one of the plaintiffs and the appellant in the *Helen L.* case, had been determined to be eligible to receive attendant care services in her own home, but was nevertheless not provided with such services, allegedly due to a lack of state funding. "Consequently," the court of appeals noted,

the Commonwealth continues to spend approximately \$45,000 a year to keep Idell S. confined in a nursing home rather than spend considerably less to provide her with appropriate care in her own home.

*Ibid.* The court of appeals found it ironic that the state "assert[ed] a justification of administrative convenience to resist an accommodation which would save an average of \$34,500 per year[.]" *Id.* at 338. It concluded, harmoniously with the decision of both courts below in this case, that such costly and medically unnecessary institutionalization of an individual eligible for community-based care could not withstand the ADA's directive to provide services in the most integrated setting.

Congress was well aware at the time it passed the ADA of the cost issues implicated by unnecessary institutionalization of persons with disabilities.<sup>22</sup> As a report repeatedly cited in the Senate report on the ADA legislation stated:

Virtually all the relevant literature documents that segregating handicapped people in large, impersonal institutions is the most expensive means of care. Evidence suggests that alternative living arrangements

<sup>22</sup> As the then-U.S. Senate Majority Leader, Bob Dole, had recognized, Congress needed to redirect expenditures away from "costly institutions" and toward "home and community-based long-term care services." Bob Dole, *Foreword*, in DAVID BRADDOCK, *FEDERAL POLICY TOWARD MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES* xv (1987).

allowing institutionalized residents to return to the community can save money. As a Federal court has noted, "Comparable facilities in the community are generally less expensive than large isolated state institutions."

*Accommodating the Spectrum, supra*, at 78-79 (footnotes omitted).

In short, the judgment below threatens neither material disruption of state programs nor any precipitous increase in state budgets for the treatment of persons with mental disabilities, notwithstanding the submissions of Petitioners and their supporting *amici*. Rather, affirmance of the judgment below will carry out the clear legislative purpose of the ADA to eliminate the legacy of segregation and integrate individuals with disabilities into the mainstream of American life.

## CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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MARCH 1999



98-536

IN THE  
SUPREME COURT OF THE UNITED STATES

October Term, 1998

**TOMMY OLMSTEAD, Commissioner of the  
Department of Human Resources of the State of Georgia,  
et al.,  
Petitioners,**

**v.**

**L. C. and E.W., each by JONATHAN ZIMRING, as  
guardian ad litem and next friend,  
Respondents.**

On Writ of Certiorari to the United States Court of Appeals  
for the Eleventh Circuit

**BRIEF OF AMICI CURIAE PEOPLE FIRST OF  
GEORGIA, SELF-ADVOCATES BECOMING  
EMPOWERED AND ITS CONSTITUENT PEOPLE  
FIRST AND SPEAKING FOR OURSELVES  
ORGANIZATIONS IN THE SEVERAL STATES,  
AUTISM NATIONAL COMMITTEE, NATIONAL  
DOWN SYNDROME CONGRESS AND  
VISION FOR EQUALITY, INC.  
IN SUPPORT OF RESPONDENTS**

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March 15, 1999

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1988  
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CONSTITUENT STATE ORGANIZATIONS  
JOINING AS AMICI

PEOPLE FIRST OF ALABAMA  
PEOPLE FIRST OF ALASKA  
PEOPLE FIRST OF ARIZONA  
PEOPLE FIRST OF CALIFORNIA  
PEOPLE FIRST OF COLORADO  
PEOPLE FIRST OF CONNECTICUT  
PEOPLE FIRST OF DENVER  
PEOPLE FIRST OF ILLINOIS  
SELF-ADVOCATES OF INDIANA  
PEOPLE FIRST OF LOUISIANA  
MASSACHUSETTS ADVOCATES STANDING STRONG  
ADVOCATING CHANGE TOGETHER IN MINNESOTA  
PEOPLE FIRST OF MISSOURI  
PEOPLE FIRST OF NEW HAMPSHIRE  
PEOPLE FIRST OF ALBUQUERQUE (NEW MEXICO)  
THE SELF-ADVOCACY ASSOCIATION OF NEW YORK, INC.  
PEOPLE FIRST OF OHIO  
PEOPLE FIRST OF OKLAHOMA  
SPEAKING FOR OURSELVES (PENNSYLVANIA)  
ADVOCATES IN ACTION (RHODE ISLAND)  
PEOPLE FIRST OF TENNESSEE  
TEXAS ADVOCATES  
PEOPLE FIRST OF SALT LAKE CITY/PEOPLE FIRST OF  
OGDEN/PEOPLE FIRST OF CASH VALLEY (UTAH)  
VERMONT PEER SUPPORT NETWORK  
PEOPLE FIRST OF WASHINGTON  
PEOPLE FIRST OF DANE COUNTY (MADISON, WISCONSIN)  
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## TABLE OF CONTENTS

|   |    |
|---|----|
| INTERESTS OF AMICI .....  | 1  |
| SUMMARY OF ARGUMENT .....   | 3  |
| ARGUMENT .....  | 4  |
| I. The Americans with Disabilities Act<br>Unmistakably Prohibits Unnecessary<br>Segregation, Disestablishes a Regime of<br>State-Imposed Segregation and Isolation,<br>and Requires that State Actions with Respect<br>to People with Disabilities Be Based Not<br>in Ignorance, Prejudice and Stereotype,<br>but in Knowledge and Thoughtfulness. .... | 4  |
| A. With Unmistakable Clarity, the Act<br>Prohibits Unnecessary Segregation. ....  | 4  |
| B. The Act Prohibits the Arbitrary Quality<br>of Thoughtlessness. ....  | 7  |
| C. The Act Seeks to Disestablish the Regime<br>of State-Imposed Segregation and Isolation<br>and to Remedy Its Effects. ....  | 11 |
| II. Petitioners Mistake the Purport of the Act and<br>Its Effects, Misstate Its Language, Ignore<br>Judicial Application of Section 504 to Remedy<br>Unnecessary Segregation and Overlook Availability<br>of Title XIX Funds to Provide Services in<br>Most Integrated Settings. ....   | 15 |
| A. The Act Establishes No <i>Per Se</i> Duty,<br>But Prohibits Only Unnecessary Segregation. ....   | 15 |

|  |    |
|--|----|
| B. "Handicap Services" Are Not Peculiar or Unique, But in the Main Are Services Commonly Provided by Governments to Non-Disabled Citizens. ....  | 19 |
| C. Section 504 <i>Had</i> Been Held by Courts to Prohibit Unnecessary Segregation. ....  | 21 |
| D. The Medical Assistance Statute Is in No Way Contrary to the Act, but Itself Contains a Parallel Prohibition on Unnecessary Utilization of Institutions and Nursing Homes and Provides Substantial Federal Funds for Services Provided in Integrated, Community Settings. .... | 25 |

|  |    |
|--|----|
| III. For Amici, the Act Has Been a Doorway to Freedom, Citizenship, and Productive, Participating and Contributing New Lives. .... | 28 |
|--|----|

|                  |    |
|------------------|----|
| CONCLUSION ..... | 30 |
|------------------|----|

|            |  |
|------------|--|
| APPENDIX A | Compendium of Purposeful State Action for the Segregation and Exclusion of Retarded Persons in the Fifty States and the District of Columbia                           |
| APPENDIX B | The Cleburne Ordinance is Part of a Pattern of State-Imposed, Life-Long Segregation of Purposeful Unequal Treatment and is Parallel to the Treatment of Black Persons. |
| APPENDIX C | Compendium of Materials and Statements of Amici People First and Speaking for Ourselves  |

|            |   |
|------------|---|
| APPENDIX D | Bibliography and Compendium of Experiences with Community Integration   |
| APPENDIX E | Compendium of Legislative Hearings and Official Reports upon which the Congress Relied in Determining the Nature and Extent of Discrimination   |
| APPENDIX F | Average Per Capita Cost of Public Institutions and Home and Community-Based Waiver Programs for People with Developmental Disabilities by State |



## TABLE OF AUTHORITIES

### FEDERAL CASES

|   |                         |
|---|-------------------------|
| <u>Alexander v. Choate</u> , 469 U.S. 287 (1985) . . . . .  | 7, 18, 21               |
| <u>Ass'n for Retarded Citizens v. Sinner</u> , 942 F.2d 1235<br>(8th Cir. 1991) . . . . .               | 24                      |
| <u>Ass'n for Retarded Citizens v. Sinner</u> ,<br>C.A.No. A1-80-141 (D.N.D. Apr. 29, 1992) . . . . .    | 24                      |
| <u>Bogard v. Duffy</u> , C.A. No. 88-C-2424 (N.D.Ill.) . . . . .  | 21, 26                  |
| <u>Bogard v. Kustra</u> , C.A. No. 88-C-2414 (N.D.Ill.) . . . . .                                       | 24                      |
| <u>Bragdon v. Abbott</u> , 524 U.S. 624 (1998) . . . . .  | 8                       |
| <u>Buck v. Bell</u> , 274 U.S. 200 (1927) . . . . .   | 7                       |
| <u>City of Cleburne, Texas v. Cleburne Living Center</u> ,<br>473 U.S. 432 (1985) . . . . .             | 2, 6, 9, 10, 11, 12, 18 |
| <u>Garrity v. Gallen</u> , 522 F. Supp. 171 (D.N.H. 1981) . . . . .                                     | 21, 22                  |
| <u>Garrity v. Gallen</u> , 697 F.2d 452 (1st Cir. 1983) . . . . .                                       | 22                      |
| <u>Halderman v. Pennhurst State School &amp; Hosp.</u> ,<br>610 F. Supp. 1221 (1985) . . . . .          | 21                      |
| <u>Halderman v. Pennhurst State School &amp; Hosp.</u> ,<br>612 F.2d 84 (3d Cir. 1979) . . . . .        | 22                      |
| <u>Halderman v. Pennhurst State School and Hospital</u> ,<br>446 F. Supp. 1295 (E.D.Pa. 1978) . . . . . | 21                      |

|  |            |
|--|------------|
| <u>Halderman v. Pennhurst State Sch. &amp; Hosp.</u> ,<br>784 F. Supp. 215 (E.D. Pa. 1992), <i>aff'd</i> ,<br>977 F.2d 568 (3d Cir. 1992) . . . . .  | 22         |
| <u>Helen L. v. DiDario</u> , 46 F.3d 325 (1995), <i>cert.den. sub nom.</i> ,<br><u>Pennsylvania Sec. of Pub. Welfare v. Idell S.</u> . . . . .   | 21, 22     |
| <u>Hobson v. Hansen</u> , 269 F. Supp. 401 (D.D.C. 1967) . . . . .   | 11         |
| <u>Homeward Bound v. Hissom Mem. Center</u> ,<br>1987 WL 27104 (N.D.Okla.) . . . . .   | 21, 22, 26 |
| <u>Homeward Bound v. Hissom Mem. Center</u> ,<br>C.A. No. 85-C-437-E (May 20, 1988) . . . . .  | 23         |
| <u>Jackson v. Fort Stanton Hospital and Training Sch.</u> ,<br>757 F. Supp. 1243 (D.N.M. 1988)<br><i>rev'd in part on other grounds</i> ,<br>964 F.2d 980 (10th Cir. 1992) . . . . .       | 21, 23, 26 |
| <u>Jackson v. Fort Stanton Hospital and Training School</u> ,<br>No. 87-839 (Oct. 5, 1988) . . . . .   | 26         |
| <u>Kentucky Ass'n for Retarded Citizens v. Conn.</u> ,<br>510 F.Supp. 1233 (W.D.Ky. 1980)<br><i>aff'd</i> 674 F.2d 582 (6th Cir. 1982)<br><i>cert. den.</i> 459 U.S. 1041 (1982) . . . . . | 24         |
| <u>L.C. and E.W. v. Olmstead</u> ,<br>1997 U.S. Dist. LEXIS 3540 (N.D.Ga. March 25, 1997) . . . . .  | 28         |
| <u>Lloyd v. Transit Authority</u> ,<br>548 F.2d 1277 (7th Cir. 1976) . . . . .   | 22         |
| <u>Lynch v. Maher</u> , 507 F. Supp. 1268 (D.Conn. 1981) . . . . .   | 21, 22     |

|   |            |
|---|------------|
| <u>Messier v. Southbury Training School</u> ,<br>916 F. Supp. 133 (D.Conn. 1996) .....  | 26         |
| <u>Meyer v. Nebraska</u> , 262 U.S. 390 (1923) .....  | 7          |
| <u>New York State Ass'n for Retarded Children v. Carey</u> ,<br>551 F. Supp. 1165 (E.D.N.Y. 1982) .....                               | 22         |
| <u>Pennsylvania Ass'n for Retarded Children v.</u><br><u>Commonwealth of Pennsylvania</u> ,<br>343 F. Supp. 279 (E.D. Pa. 1972) ..... | 12         |
| <u>Pennsylvania Dep't of Corrections v. Yeskey</u> ,<br>118 S.Ct. 1952, 524 U.S. 206 (1998) .....                                     | 5          |
| <u>Pennsylvania Sec. of Public Welfare v. Idell S.</u> ,<br>516 U.S. 813 (1995) .....   | 21         |
| <u>Richard C. v. White</u> ,<br>C.A. No. 89-2038 (W.D.Pa.) .....  | 21, 24, 26 |
| <u>School Board of Nassau Co., Florida v. Arline</u> ,<br>480 U.S. 273 (1985) .....   | 8, 9       |
| <u>School Comm. of Burlington v.</u><br><u>Mass. Dept. of Educ.</u> , 471 U.S. 359 (1985) .....                                       | 12         |
| <u>Traynor v. Turnage</u> , 485 U.S. 535 (1998) .....   | 23         |

#### LEGISLATIVE MATERIALS

|                                      |        |
|--------------------------------------|--------|
| 113 Cong. Rec. 11417 (1967) .....    | 25, 26 |
| 117 Cong. Rec. 45945 (1971) .....    | 7      |
| 117 Cong. Rec. 45974-75 (1971) ..... | 8      |

|   |                      |
|---|----------------------|
| 117 Cong. Rec. 42293-94 .....                                     | 8                    |
| 118 Cong. Rec. 525 (1972) .....                                   | 8                    |
| 118 Cong. Rec. 9495 (1972) .....                                  | 8                    |
| 118 Cong. Rec. 9495-9501 (1972) .....                             | 8                    |
| 135 Cong. Rec. S4984 (May 9, 1989) .....                          | 5                    |
| 135 Cong. Rec. S4986 (May 9, 1989) .....                          | 24                   |
| 136 Cong. Rec. S9688 (Jul. 13, 1990) .....                        | 5                    |
| H.R. Rep. 101-485 (II), (III),<br>1990 U.S.C.C.A.N. ....          | 5, 6, 17, 20, 25, 28 |
| S. Rep. No. 744, 90th Cong., 2nd Sess.,<br>1967 U.S.C.C.A.N. .... | 26                   |

#### FEDERAL STATUTES

|                                      |      |
|--------------------------------------|------|
| 20 U.S.C. §1412(a)(5) .....          | 12   |
| 28 C.F.R. §5.130(d)(1991) .....      | 6    |
| 28 C.F.R. §35.130(d) .....           | 16   |
| 28 C.F.R. Pt. 35 App. A (1991) ..... | 6    |
| 28 C.F.R. §35.130(b)(1)(iv.) .....   | 23   |
| 42 C.F.R. §456.371 .....             | 25   |
| 42 U.S.C. §12101 et seq. ....        | 4, 5 |



|  |            |
|--|------------|
| 42 U.S.C. §1396a (a)(30)(A) et seq. .... | 25         |
| 42 U.S.C. §12112(b)(1) .....             | 6, 18      |
| 42 U.S.C. §12134 .....                   | 5          |
| 42 U.S.C. §12182(b)(1)(B) .....          | 5, 18      |
| 42 U.S.C. §12201(a) .....                | 6, 21      |
| 42 U.S.C. ch. 35A .....                  | 19         |
| 42 U.S.C. §1751 .....                    | 19         |
| 7 U.S.C. §§1431, 2011 et seq .....       | 19         |
| Title XIX, 42 U.S.C. §§1396 et seq. .... | 19, 20, 26 |

#### STATE STATUTES

|   |    |
|---|----|
| 1957 Ga. Laws 306 .....   | 14 |
| S.J. Res.44, 1918 Ga.Gen.Assembly Ann.Sess.,<br>1918 Ga. Laws 921 ..... | 13 |
| 1919 Ga. Laws 377 .....   | 13 |

#### BOOKS AND ARTICLES

|   |    |
|---|----|
| American Academy of Pediatrics,<br>MEDICAID STATE REPORTS -- FY 1996 (1998) ..... | 27 |
| ARGUMENT (1989) .....   | 30 |

|   |            |
|---|------------|
| DAVID BRADDOCK et al.,<br>THE STATE OF THE STATES<br>IN DEVELOPMENTAL DISABILITIES (1998) ..... | 18, 27, 29 |
|---|------------|

|   |             |
|---|-------------|
| EDWARD J. LARSON, SEX, RACE AND SCIENCE:<br>EUGENICS IN THE DEEP SOUTH (1995) ..... | 14, 14 n.14 |
|---|-------------|

|  |    |
|--|----|
| H.H. GODDARD, THE KALIKAK FAMILY:<br>A STUDY IN THE HEREDITY<br>OF THE FEEBLEMINDED (1912) ..... | 14 |
|--|----|

|                                  |    |
|----------------------------------|----|
| <i>Impact</i> (Vols. 1-12) ..... | 30 |
|----------------------------------|----|

|   |   |
|---|---|
| Karst, <i>The Supreme Court, 1976 Term --<br/>Forward: EqualCitizenship Under the<br/>Fourteenth Amendment</i> , 91 HARV. L. REV.1, 6 (1977) .. | 3 |
|---|---|

|   |    |
|---|----|
| NATIONAL ASS'N OF STATE DIRECTORS<br>OF DEVELOPMENTAL DISABILITIES SERVICES,<br>THE HCB WAIVER AND CSLA PROGRAMS:<br>AN UPDATE ON MEDICAID'S ROLE ..... | 28 |
|---|----|

|   |    |
|---|----|
| STEVEN NOLL, FEEBLE-MINDED IN OUR MIDST (1995) .. | 14 |
|---|----|

|   |    |
|---|----|
| UNITED STATES CIVIL RIGHTS COMMISSION, ACCOMMODATING<br>THE SPECTRUM OF INDIVIDUAL ABILITIES (1983) ..... | 15 |
|---|----|

## INTERESTS OF AMICI

Amici are grass roots organizations of Americans with disabilities, People First, whose initial chapters were established in 1974, now number more than 900 with nearly 20,000 active members in 46 states and who in this decade have joined together nationally as Self-Advocates Becoming Empowered.<sup>1</sup> Some three-quarters of the members were once segregated into institutions and now are not.

To this network of citizens:

Self-advocacy is about independent groups of people with disabilities working together for justice by helping each other take charge of their lives and fight discrimination. ... It teaches us about our rights, but along with learning about our rights, we learn responsibilities. The way we learn about advocating for ourselves is supporting each other, and help each other gain confidence in themselves to speak out for what they believe in.

Self-Advocates act together in friendship to extend welcome, practical assistance and mutual support to people coming from institutions into community, to teach teachers, care-givers, bureaucrats, political leaders, family, friends, one another, and the public to listen and to hear what people with disabilities believe they need and to take the benefit of what people with disabilities have learned. As next friends to still-institutionalized persons and organizational plaintiffs, self-advocates have directed the conduct of litigation. As monitors, as well as friends and supporters, self-advocates have acted to assure that planned and ordered moves to community are well done and that no one is lost.

Although professional opinion, research findings, and the experience of people with disabilities consistently favor non-institutional services, some institutionalized professionals, policy makers and parents continue to support segregated long-term care. For example, service providers continue to

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<sup>1</sup> The parties have consented to the filing of this brief. No counsel for a party has authored this brief in whole or in part, and no person other than *amici* and its counsel made any monetary contribution for its preparation.



exercise a great deal of control over the lives of self-advocates, some parents favor institutionalization, and many policy-makers fiscally support large congregate care facilities. Believing that individuals with disabilities can no longer wait for others to change the long-term care system, self advocates resolved to become more active in changing the system which does not work for them: "We believe that all institutions, both private and public, should be closed. All people regardless of the severity of their disabilities should live in the community with the support they need." Materials from Self-Advocates Becoming Empowered's Close the Doors: Campaign for Freedom are attached hereto in Appendix C.

People First of Georgia has more than 350 members in 14 chapters throughout the State engaged in the friendship and work common everywhere to Self-Advocates. Its members "were so happy when the 11th Circuit decided that L.C. and E.W. had been discriminated against by being confined in a state institution," because "we believe that forcing people to live in institutions instead of their own houses in their own communities violates their human rights and is against the principles of the Americans with Disabilities Act."

Established in 1972 and 1974, respectively, as organizations of families and professionals, the Autism National Committee and National Down Syndrome Congress are increasingly devoted to empowering people with Autism and Down Syndrome, including as officers and directors and fully as citizens. Vision for Equality is an organization of people with disabilities, their families and friends, and rooted in Philadelphia. It seeks to give another strand of meaning to the Independence and Equal Citizenship annually celebrated at the nation's Independence Hall.

Many Amici here were amicus also in City of Cleburne, Texas v. Cleburne Living Center, 473 U.S. 432, 461 (1985). What is at stake for Amici here is what was there at stake: "human freedom and fulfillment -- the ability to form bonds and take part in the life of a community." As the citizens they are, Amici and many members participated in the formulation

and enactment, by a near unanimous Congress, of the statute whose efficacy or not depends upon this Court's decision in this case.

Amici write to put before the Court desegregation as they have experienced it, the weight of the invidious history as they have suffered it, and a sense of the freedom and responsibility of citizenship as they now live it.

## SUMMARY OF ARGUMENT

The Act assures to Americans with disabilities the benefits of "the principle of equal citizenship [that] presumptively insists that the organized society treat each individual as a person, one who is worthy of respect, one who 'belongs.' Stated negatively, the principle presumptively forbids the organized society to treat an individual either as a member of an inferior or dependent caste or as a non-participant."<sup>2</sup>

The Act prohibits unnecessary segregation into institutions and nursing homes. Whether segregation is unnecessary -- whether a person's needs can be met in a more segregated setting -- is to be determined thoughtfully, based in knowledge and free of ignorance, prejudice or stereotypes.

The regime of state-imposed segregation and degradation has continued its impositions into the lives of Respondents and many other individuals with disabilities. The Act seeks and requires its disestablishment.

The Attorney General's regulation (1991) faithfully implements the controlling Congressional direction to prohibit unnecessary segregation, faithful alike to integration provisions in both of the Act's other titles and to the specified 1978 coordinating regulation, and faithfully applying a standard no less than that judicially applied under Section 504. Implementation of the integration imperative, far from affronting the medical assistance program (Title XIX of the Social Security Act)

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<sup>2</sup> Karst, *The Supreme Court, 1976 Term -- Forward: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1,6 (1977)

which contains its own independent prohibition of unnecessary utilization of institutions and nursing homes, can be funded by Title XIX, variously with a 50% to 82% federal financial share, as far as a state chooses.

What Amici People First and Speaking for Ourselves Organizations seek in this Case is nothing less than what one of their first members sought after twenty years segregated into a Massachusetts institutions on the eve of his move into Massachusetts' community: "I want to be a citizen. I want to do what every citizen can do. Citizenship means voting. Citizenship means working, it means helping others. It also means that we are able to make important decisions for ourselves. Our families and the people who work with us can help us, but if citizenship is to mean anything we must make the final decision." CHERINGTON & DYBWAD, PRESIDENT'S COMM. ON MENTAL RETARDATION, NEW NEIGHBORS: THE RETARDED CITIZEN IN QUEST OF A HOME 198 (1974).

## ARGUMENT

### **I. The Americans with Disabilities Act Unmistakably Prohibits Unnecessary Segregation, Disestablishes a Regime of State-Imposed Segregation and Isolation, and Requires that State Actions with Respect to People with Disabilities Be Based Not in Ignorance, Prejudice and Stereotype, but in Knowledge and Thoughtfulness.**

#### **A. With Unmistakable Clarity, the Act Prohibits Unnecessary Segregation.**

The Congress of the United States, subscribed by the President, purposefully "invoke[d] the fullness of its powers including the power to enforce the Fourteenth Amendment... in order to address the major areas of discrimination faced day-

to-day by people with disabilities."<sup>3</sup> Foremost among the "forms of discrimination" to be remedied, Congress explicitly ranked the historical "isolat[ion] and segregat[ion] of individuals with disabilities."<sup>4</sup>

The "unambiguous statutory text of the Americans with Disabilities Act," Pa. Dept. of Corrections v. Yeskey, 118 S.Ct. 1952, 1956 (1998), requires the Attorney General to promulgate regulations and, with respect to state and local government services, directs that the regulations "shall be consistent with this Chapter and with the co-ordination

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<sup>3</sup> 42 U.S.C. § 12101(b)(4).

<sup>4</sup> 42 U.S.C. § 12101(a)(2). And see § 12101(a)(5). Senator Harkin, floor manager and prime sponsor, closing debate in the Senate, said:

[T]oday Congress opens the door to all Americans with disabilities; . . . today we say no to fear, . . . we say no to ignorance, and . . . we say no to prejudice. The ADA is, indeed, the 20th century Emancipation Proclamation for all persons with disabilities. Today, the U.S. Senate will say to all Americans that the days of segregation and inequality are over. 136 Cong. Rec. S9688 (Jul. 13, 1990). At introduction of the bill, see 135 Cong. Rec. S4984 (May 9, 1989). H.R. Rep. 101-485(II)(Educ. and Labor Comm.) at 50, 1990 U.S.C.C.A.N. at 332, concluded:

[T]here is a compelling need to provide a clear and comprehensive national mandate for the elimination of discrimination and for the integration of persons with disabilities into the economic and social mainstream of American life.

H.R. Rep. 101-485(III)(Judiciary Comm.) at 26, 1990 U.S.C.C.A.N. at 49, opened:

The Americans with Disabilities Act completes the circle begun in 1973 with respect to persons with disabilities by extending to them the same civil rights protections provided to women and minorities beginning in 1964. This year, 1990, is an historic one in the evolution of this nation's public policy towards persons with disabilities. The ADA is a comprehensive piece of civil rights legislation which promises a new future: a future of inclusion and integration and the end of exclusion and segregation.



regulations"<sup>5</sup>...and that the Act shall not "be construed to apply a lesser standard than the standards applied under Title V of the Rehabilitation Act of 1973 or [its] regulations."<sup>6</sup>

The Attorney General promptly and faithfully complied with what is under the Fourteenth Amendment "controlling congressional direction." City of Cleburne, Texas v. Cleburne Living Center, 473 U.S. 432, 439 (1985). His regulation, 28 C.F.R. §35.130(d)(1991)(emphasis supplied), requires with unmistakable clarity that:

a public entity shall administer services, programs and activities in the most integrated **setting** appropriate to the needs of qualified individuals with disability.<sup>7</sup>

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<sup>5</sup> 42 U.S.C. §12134. The Act -- "this chapter" -- at §302(b), 42 U.S.C. §12182(b)(1)(B), entitled "Integrated Settings," requires: "Goods, services, facilities, privileges, advantages, and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to the needs of the individual."

At §102(b), 42 U.S.C. §12112(b)(1), entitled "Discrimination" -- "Construction," the Act provides: "the term 'discriminate' includes . . . segregating . . . in a way that adversely affects the opportunities or status of [a person] because of . . . disability."

As to these provisions, H.R. Rep. (II) at 84; 1990 U.S.C.C.A.N. at 367 instructed: "The Committee intends . . . that the forms of discrimination prohibited by section 202 be identical to those set out in the applicable provisions of titles I and III of this litigation. Thus, for example, the construction of "discrimination" set forth in section 102(b) and (c) and section 302(b) should be incorporated in the regulations implementing this title."

The co-ordination regulation to which §12134 directs the Attorney General, requires: "Recipients shall administer programs and activities in the most integrated setting appropriate to the needs of qualified handicapped persons."

<sup>6</sup> 42 U.S.C. §12201(a).

<sup>7</sup> Petitioner's attempt to insinuate that a *per se* requirement--no segregation under any circumstances, ever-- is at issue in this case thus defies the Acts' plain language. It is "**unnecessary segregation**" which is prohibited. This is Respondents' position and was so below. It was the holding of the Courts below, and also of the other courts which have enforced the integration imperative under this Act and under 504. See Argument II. A,

Of this regulation, the Attorney General, at 28 C.F.R. Pt. 35, App. A at 478 (1991) comments:

[T]he public entity must administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities, i.e. in a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible.

## **B. The Act Prohibits the Arbitrary Quality of Thoughtlessness.**

The Court's modern consideration of Americans with disabilities<sup>8</sup> has identified the values which Congress has legislated consistently to achieve. These Congressionally chosen and plainly legislated values determine the outcome of this case.

In Alexander v. Choate, for example, a unanimous Court recognized "the statutory rights of the handicapped to be integrated into society" to be among the "statutory objectives" of Section 504 which "need to [be] give[n] effect." 469 U.S. 287, 300, 299 (1985). "[T]houghtlessness and indifference" and "well-catalogued instances of invidious discrimination", Choate says, were both perceived by Congress to give rise to redressable wrongs. Invoking the original Senate and House sponsors of 504, Choate recognized among the wrongs Congress meant to remedy both "the invisibility of the handicapped in America" and that "the handicapped... live... 'shunted aside, hidden, and ignored'." *Id.* at 295-96, 296 n.12.<sup>9</sup>

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infra.

<sup>8</sup> The early century, non-statutory cases include, at the poles, Meyer v. Nebraska, 262 U.S. 390, 401-02 (1923) and Buck v. Bell, 274 U.S. 200 (1927).

<sup>9</sup> Both Sponsors had unnecessary institutional segregation in mind. Congressman Vanik's full statement was:

In School Bd. of Nassau Co., Florida v. Arline, 480 U.S. 273 (1985), the Court applied Congress' legislated intention to forbid "discriminatory practices ... which stemmed ... from stereotypical attitudes and ignorance about the handicapped" and to protect "the handicapped against discrimination stemming not only from simple prejudice, but also from 'archaic attitudes and laws' and from 'the fact that the American people are ... unfamiliar with and insensitive to ... individuals with handicaps.'" *Id.* at 279 n.3, 279. Given the many sources of harmful error about people with disabilities, a central requirement, the Court writes in Bragdon v. Abbott, 118 S.Ct. 2196 (1998), is that decisions reached by the Act must be based upon facts, upon "objective facts" and upon the "objective reasonableness" of the "assessment of the objective facts." *Id.* at 2210.

"[T]he basic purpose of §504 is to ensure that

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The masses of the handicapped live and struggle among us, often shunted aside, hidden and ignored. How have we as a nation treated these fellow citizens? In this country we still have the snakepit mental institutions for confinement without treatment, where brutality and unexplained deaths are common. 117 Cong. Rec. 45945 (1971).

Senator Humphrey's:

I am calling for public attention to three-fourths of the Nation's institutionalized mentally retarded, who live in ... facilities ... more than 50 years old, functionally inadequate and designed simply to isolate these persons from society ... These people have the right to live, to work to the best of their ability -- to know the dignity to which every human being is entitled. But too often we keep children, whom we regard as 'different' or a 'disturbing influence' out of our schools and community activities altogether ... Where is the cost-effectiveness in ... consigning them to 'terminal' care in an institution? 118 Cong. Rec. 525 (1972).

See also 118 Cong. Rec. 9495 (1972), (Senator Humphrey).

In 504 legislative history, acting against institutional segregation of people with disability is repeatedly linked with including them into community services. E.g. 117 Cong. Rec. 45974-75 (1971) (sponsors intend to remedy differential access by disabled to schooling, armed services training, Job Corps, vocational training, family services); *Id.* at 42293-94 (schooling, job training, family services, foster care, recreation); 118 Cong. Rec. 9495-9501 (1972) (schooling, job training public employment services, pre-school programs, group homes).

handicapped individuals are not denied jobs or other benefits [or otherwise discriminated against] because of the prejudiced attitudes or the ignorance of others." 480 U.S. at 284 (bracket supplied). "Congress," the Arline Court wrote, has "acknowledged that society's accumulated myths and fears about disability and disease are as handicapping as are the... limitations that flow from actual impairment." "The Act," the Court held, "is carefully structured to replace such reflexive reactions to actual and perceived handicaps with actions based upon reasoned and ... sound judgments. ... [D]iscrimination on the basis of mythology [is] precisely the type of injury Congress sought to prevent." *Id.* at 284-85.

By prescribing that any services, programs, or activities which a state undertakes to provide to a disabled individual must be provided in the most integrated setting appropriate to the needs of qualified individuals with disabilities, the Act requires two things: thoughtful judgment, free alike of stereotype and ignorance, and, if the needs of the individual with disabilities can be met in an integrated setting--i.e., segregation is unnecessary-- then it is in such a setting that the services must be provided.

The conjunction of thoughtfulness, integration and disability is familiar to the Court. Acting under the Equal Protection Clause, the Court in City of Cleburne, Texas v. Cleburne Living Center, 473 U.S. 432 (1985), unanimously held that: "retarded individuals cannot be grouped together as the 'feeble-minded' and deemed presumptively unfit to live in a community." *Id.* at 455.

All members of the Cleburne Court joined unanimously to establish "the principle that mental retardation *per se* cannot be a proxy for depriving people of their rights and interests without regard to variations in individual ability. The Equal Protection Clause requires attention to the capacities and needs of retarded people as individuals." *Id.* at 455-56 (Opinion of Marshall, J.).

At issue in Cleburne was the constitutionality of an ordinance rooted in the early century which required an annual,



special use permit for homes for "the insane or feeble-minded." *Id.* at 436 n.3. The Court accepted findings below that "without group homes... the retarded could never hope to integrate themselves into the community." *Id.* at 438, 439 n.6 (White, J.).

Although three Opinions differed in the Equal Protection standard each said it was applying, each reached the same conclusion. The Opinion of the Court per Justice White concluded: "The short of it is that requiring the permit in this case appears to us to rest on an irrational prejudice against the mentally retarded...." *Id.* at 450.<sup>10</sup>

Five members of the Cleburne Court found that the historical treatment of persons with disabilities entered into the unconstitutional application, and adoption, of the City's ordinance. For Justice Stevens and the then Chief Justice, the questions were: Has the class disfavored by the ordinance "been subjected to a 'tradition of disfavor' by our laws? What is the public purpose that is being served by the law? What is

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<sup>10</sup> That Opinion analyzed and rejected six distinct grounds actually proffered by the City, finding some to be "based on . . . vague undifferentiated fears" and some to be "mere negative attitudes, or fear, unsubstantiated by factors which are properly cognizable in a zoning proceeding, and [which] are not permissible bases for treating a home for the mentally retarded differently ...." *Id.* at 448, 449. "The question," Justice White wrote, "is whether it is rational to treat the mentally retarded differently. It is true that they suffer disability not shared by others; but why this difference warrants a density regulation that others need not observe is not at all apparent ... At least this record does not clarify how ... the characteristics of the intended occupants of the Featherston home rationally justify denying to those occupant's what would be permitted to groups occupying the same site for different purposes." *Id.* at 449-50 (emphases added).

Although segregation in institutions presents the contra-positive of the Cleburne situation (putting disabled people somewhere no one else is put vs. disallowing disabled people from residing where others reside), if it is unnecessary segregation--i.e., not justified by any difference arising from retardation--then, it would appear, unnecessary segregation into institutions would, on Justice White's analysis, also fall before the Equal Protection Clause.

the characteristic of the disadvantaged class that justifies the disparate treatment?" *Id.* at 453. They found that "through ignorance and prejudice the mentally retarded have been subjected to a history of unfair and often grotesque mistreatment," that the real purpose of the ordinance is to satisfy "the irrational fears of neighboring property owners, rather than for the protection of mentally retarded persons..." and that justification for the disparate treatment is "wholly unconvincing." *Id.* at 453-55.

The third opinion in Cleburne set out the "history of unfair and grotesque mistreatment" to which Justice Stevens adverted and the history of "irrational prejudice" found in Justice White's Opinion to be at the root of Cleburne's exclusionary ordinance. *Id.* at 454, 450.

The arbitrary quality of thoughtlessness,<sup>11</sup> which the Act bans, has Constitutional dimension.

### **C. The Act Seeks to Disestablish The Regime of State-Imposed Segregation and Isolation and to Remedy Its Effects.**

Justice Marshall, joined by Justices Brennan and Blackmun, described the "lengthy and tragic history of segregation and discrimination that can only be called grotesque" in part as follows:

"During much of the 19th century, mental retardation was viewed as neither curable nor dangerous and the retarded were largely left to their own devices. By the latter part of the century and during the first decades of the new one, however, social views of the retarded underwent a radical transformation. Fueled by the rising tide of Social Darwinism, the 'science' of eugenics, and the extreme xenophobia of those years, leading medical authorities and others began to portray the 'feeble-minded' as a 'menace to society and civilization ...

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<sup>11</sup> See Hobson v. Hansen, 269 F. Supp. 401, 497 (D.D.C. 1967) (Wright, C.J.).

responsible in a large degree for many, if not all, of our social problems.'

"A regime of state-mandated segregation and degradation soon emerged that in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow. Massive custodial institutions were built to warehouse the retarded for life; the aim was to halt reproduction of the retarded and 'nearly extinguish their race.' Retarded children were categorically excluded from public schools, based on the false stereotype that all were ineducable and on the purported need to protect nonretarded children from them.<sup>12</sup> State laws deemed the retarded 'unfit for citizenship.'" 473 U.S. at 461-463 (citations and footnotes omitted).

The regime of state-mandated segregation and degradation extended throughout the States.<sup>13</sup> The invidious actions of the States not only established the pattern of segregation which Respondents here have so recently escaped - thirty-three years ago, when she was 14 years old, E.W. was sent to the very state institution which had been created by law in 1919 as the "Georgia Training School for Mental Defectives," J.A. 106 -- but they constituted State

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<sup>12</sup> The unanimous Opinion in School Comm. of Burlington v. Mass. Dept. of Educ., 471 U.S. 359, 373 (1985), observed that in the Education of all Handicapped Children Act of 1975, "Congress was concerned about the apparently wide-spread practice of relegating handicapped children to ... institutions or warehousing them in special classes." See PARC v. Commonwealth of Pennsylvania, 343 F. Supp. 279, 293-297 (E.D. Pa. 1972). The Education Act contains an integration imperative parallel to that here. 20 U.S.C. §1412(a)(5).

<sup>13</sup> "A Compendium of Purposeful State Action for the Segregation and Exclusion of Retarded Persons in the Fifty States and the District of Columbia" which sets forth the enactments of the states and official materials surrounding them is attached to this Brief as Appendix A. The Compendium was originally submitted to the Court in the Cleburne Case in an Amici Curiae Brief filed there by organizations who appear as Amici here. Secondary sources concerning the pervasive state action and Amici's analysis thereof, also drawn from their Cleburne Brief, are set forth here as Appendix B.

confirmation and perpetuation of the very stereotypes, prejudice and ignorance which had driven the States' invidious actions. As Justice Marshall wrote: "Prejudice, once let loose, is not easily cabined... [L]engthy and continuing isolation of the retarded has perpetuated the ignorance, irrational fears, and stereotyping that long have plagued them." 473 U.S. at 464.

Georgia participated in this regime of segregation. In 1918 Georgia's General Assembly found that: "there are many persons in Georgia, minor and adults, who are feeble-minded and as such are a menace to the schools and to the communities in which they reside" and "More than three fourths of the States in the United States make special provision for the care, detention and training of the feeble-minded and for the prevention of the evils resulting from their neglect and their being allowed at large to marry and perpetuate and increase the serious tendencies of their unhappy conditions."

The Assembly requested that before the next session the Governor: "appoint a committee ... to investigate fully and ... to make recommendations ... to relieve the State of the menace of the uncared-for feeble-minded who are such a fertile source of crime, poverty, prostitution and misery not only to themselves, but to all with whom they are brought into contact." S.J. Res. 44, 1918 Ga. Gen. Assembly Ann.Sess., 1918 Ga. Laws 921. On June 26, 1919, the Governor transmitted the Report of the Commission on the Feeble-minded to the legislature and urged that "steps be taken immediately along the lines suggested." Journal of the Ga. House, June 30, 1919 at 205.

In the ultimate sentence of the last page of its sixty page Report, the Commission recommended the enactment of "Laws for the Commitment of the Feeble-minded ... making the usual provisions for the protection, care, training and *segregation* of mental defectives." Journal of the Ga. House, June 30, 1919, 205-264 at 264; Journal of the Ga. Senate, July 2, 1919, 142-201 at 201 (emphasis supplied).



Eight days after receiving the Report, the Georgia House approved the bill "establishing ... an institution to be known as the 'Georgia Training School for Mental Defectives,'" by vote of 149-19. *Id.* at 630. The Senate followed suit, by vote of 36-0 on August 1, 1919. *Journal of the Ga. Senate, 1919* at 833. The Act, 1919 Ga. Laws 377 required "thoroughly scientific ... management," the admission of "any person with mental defectiveness ... so pronounced that he or she is unable to ... manage his affairs with ordinary prudence, and ... constitutes a menace to the happiness of himself or of others in the community" and "preference in admission ... to children and women of child-bearing age."<sup>14</sup>

Georgia's statute closely followed the national pattern. The animus was everywhere the same. "Each of the new institutions was expressly and exclusively created to segregate, train, and care for a class of persons identified as feeble-minded." EDWARD J. LARSON, *SEX, RACE AND SCIENCE: EUGENICS IN THE DEEP SOUTH*, 83, 40-84 (Johns Hopkins Univ. Press, 1995); STEVEN NOLL, *FEEBLE-MINDED IN OUR MIDST: INSTITUTIONS FOR THE MENTALLY RETARDED IN THE SOUTH, 1900-1940*, 13-26 (Univ. of N.C. Press, 1995).

None of this was done quietly. H.H. GODDARD, *THE KALIKAK FAMILY: A STUDY IN THE HEREDITY OF THE FEEBLEMINDED* (1912) outsold the Bible in 1912 and, at least as late as the 1950s, was taught in three grades in public and

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<sup>14</sup> The Georgia statute, like others (see App. B. at 13), authorized health officers, school officials and "any reputable person" to override family resistance "when the relatives ... either neglect -- or refuse -- to place a said person in the Georgia Training School for Mental Defectives."

In 1957, three years after *Brown*, Georgia passed an Act "to establish a facility for Negro children [at] the Georgia Training School for Mental Defectives at Gracewood [,] distinct and separate ... for Negro children only." 1957 Ga. Laws 306. Until then, as in most southern states, institutions took only whites. The Jim Crow segregation of African Americans "allowed" the states to focus institutional segregation exclusively on "'preserving' the White race." LARSON at 93; NOLL at 26, 39.

private schools in most states. Through the medical journals and doctors "knowledge" of "the menace of the feeble-minded" was disseminated deeply into every community. Their "dangerousness," "incurability," the "social and moral costs" they imposed upon communities and the propriety, even necessity, of segregation were prominently "reported" in leading newspapers everywhere. In nearly every state, pamphleteering, and "stumping" also, was widespread. One of the champions of segregation, A.A. Johnson, for example, lectured in 350 cities and towns -- 1,100 lectures between 1915 and 1918 to two hundred fifty thousand people in all parts of the country; 95 lectures between 1913 and 1918 to some twenty thousand university students in 72 cities in 28 states.<sup>15</sup>

It is this regime of segregation and isolation, ignorance and thoughtlessness, established by force of state law, which Congress formulated and enacted the Americans with Disabilities Act to disestablish and whose effects into the present Congress sought to remedy. See Appendix E. hereto. Amici know from experience, the United States Civil Rights Commission found (1983 Report at 20), and the enacting Congress knew that segregated state institutions have achieved "a momentum of their own." From this encompassing momentum, Amici wish to be -- and the Act provides that they should be -- free.

## **II. Petitioners Mistake the Purport of the Act and Its Effects, Misstate Its Language, Ignore Judicial Application of Section 504 to Remedy Unnecessary Segregation and Overlook Availability of Title XIX Funds to Provide Services in Most Integrated Settings.**

### **A. The Act Establishes No *Per Se* Duty, But Prohibits**

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<sup>15</sup> See the materials collected in Appendices A and B, the historical works cited above, and the works cited in the bibliographic note to Amici's *Cleburne* brief.

### Only Unnecessary Segregation.

Petitioners throughout attribute to the Act duties which are not there, *e.g.*, a duty to integrate *per se*, every time, everywhere; a *per se* prohibition on segregation; in their words "an *unyielding* preference for one type of ... care over another." Br. at 30 (emphasis supplied).

The Act prohibits only *unnecessary* segregation, exactly what the courts below held and exactly what Respondents have sought, below and here. The duty is only "to administer services, programs, and activities in *the most integrated setting appropriate to the needs of qualified individuals with disabilities*." 28 C.F.R. §35.130(d).<sup>16</sup>

Once Petitioners' misstatement of the duty is in focus, it readily can be seen that their assertion that "institutionalization" in the Congressional finding<sup>17</sup> is "discrimination-neutral," Br. at 36-37, while correct, has exactly the opposite implication from the one Petitioners imply. Each of the critical areas is "discrimination-neutral." The *prohibited* discrimination with regard to institutionalization arises where it is *unnecessary* institutionalization: *i.e.*, where institutional segregation is unnecessary, *i.e.*, the needs of the person with disabilities can

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<sup>16</sup> Petitioners' statement of the question presented does not contest, but takes it as a given, that decisions about whether needs can be met in particular settings can be sensibly made. The district court found that the parties agreed that the needs of Respondents can be met in a community setting, that the institution was for Respondents, unnecessarily segregated, and that the settings sought and ordered were the most integrated settings appropriate to the needs of Respondent. 1997 U.S. Dist. LEXIS at \*8, \*15. Contrary to the assertion in the statement of question here, namely, that Respondents' needs can be met in "a State Hospital," there was no such finding below nor was such a fact agreed to by the parties.

<sup>17</sup> "The Congress finds that -- discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services."

be met in a more integrated setting.

Similarly, to see that the Act prohibits *unnecessary* segregation dispels the inference Petitioners recurrently seek to draw from such correct statements as, Br. at 26, "nothing ... require[s] States to provide [community services to disabled people] *simply* because it [is] possible, appropriate, or even better than institutional treatment (sic)." The "simply" makes the statement true. There *is* in this Act *no* right to community services *per se*, *no* right at all to community services *as such* whether they be "possible," "appropriate," "better" or whatever. The right secured by the Act is the right, whenever a state should undertake to provide services to a disabled person, that the services *not* be provided in unnecessarily segregated settings but instead in the most integrated setting where the needs of the person with disabilities can be met.<sup>18</sup>

Petitioners invoke, Br. at 39, a paragraph of the House Report which-- in the portion they omit by elision -- is telling:

The Committee intends ... that *the forms of discrimination prohibited by Section 202 be identical* to those set out in the applicable provisions of Titles I and III of this

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<sup>18</sup> In an apparent explanation of why Petitioners profess they have been unable to find clear meaning in the Act, Petitioners in their Brief to the Court *thirty-three times* use a phrase which appears *nowhere* in the Act, *nor* in its regulation, *nor* in the Committee Reports commending the Act to the entire Congress, *nor* at any time in the floor debate, and which also appears *nowhere* in the claims made by plaintiffs below, in their argument there, *or here*, or in *either* of the opinions of the courts below--namely, "least restrictive treatment."

In contrast -- and apparent acknowledgment of the unmistakable difficulty of the actual statutory language to their position here -- Petitioners use the word "segregation" just twice, Br. at 38, 41, and the phrase "unnecessary segregation" never at all, except in quoting the district court's holding. Br. at 12. Four times Petitioners quote the entirety of the phrase which is in the statute and in the regulation which determines this case, but never do they analyze or address *its* meaning. Instead Petitioners repeatedly address a concept which is not in this case, would be of dubious relevance if it were, and would implicate a multidimensional inquiry (least restrictive of what?) with no calculus for weighing dimensions. In contrast, integration or segregation has but a single dimension: interaction.



Legislation. Thus, for example, the construction of 'discrimination' set forth in *Section 102(b)* and (c) and *Section 302(b)* should be incorporated into the regulations implementing this title.

H.R. Rep.(II) at 84; 1990 U.S.C.C.A.N. at 367 (emphases supplied). Section 302(b), which by this explicit direction is to "be incorporated into the regulation implementing title [II]," itself expressly construes the discrimination prohibited, at §302(b)(1)(B), to include, and to be: "Goods, services facilities, privileges, advantages and accommodations shall be afforded to an individual with a disability in the most integrated setting appropriate to be needs of the individual." 42 U.S.C. §12182(b)(1)(B).<sup>19</sup> In Section 102(b)(1), the discrimination that is prohibited is expressly construed to include and to be: "... segregating ... in a way that adversely affects the opportunities or status of [a person] because of ... disability." 42 U.S.C. §12112(b)(1).

Thus, with unmistakable clarity, the Act prohibits unnecessary segregation, and only<sup>20</sup> unnecessary segregation. In promulgating the integration regulation, the Attorney General was following "controlling congressional direction." *City of Cleburne, Texas v. Cleburne Living Center*, 473 U.S.

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<sup>19</sup> The minority of States Amici supporting Petitioners here write in their Brief at 15 that "Congress knows very well how to enact an explicit integration mandate ... and it did so in Title III of the ADA. See 42 U.S.C. §12182(b)(1)(B)." They thus concede the point, and the case.

<sup>20</sup> This is one of the particulars in which the Act differs from Title VI of the Civil Rights Act of 1964 and disability discrimination, from race discrimination. The difference reflects, and fulfills, *Choate's* caution that "too facile an assimilation" of the two "must be resisted." 469 U.S. at 293 n.7. Just such an assimilation plagues Petitioners' position here. That the Act's bar upon segregation is thus limited does not exclude the possibility that when a State carries out its duty thoughtfully to look to see whether a person's needs can be met in a more integrated setting, it may find that all of the persons it has segregated are unnecessarily segregated: New Hampshire, Vermont, Rhode Island, New Mexico and Michigan (but for at this date 362 persons) have so found. BRADDOCK ET AL., at 27.

at 439 (1985) (Justice White's Opin. for the Court).

#### **B. Handicap Services" Are Not Peculiar or Unique, But in the Main Are Services Commonly Provided by Governments to Non-Disabled Citizens.**

Petitioners seem to argue that the State is free, as once it was (see Argument I.C. *supra*), whenever it provides services "only" to "the handicapped," to do to them and with them whatever it may wish. That defies sense as well as the text and history of the Act.

Moreover, it is incorrect. By and large, the services provided in institutions are a set of familiar generic services provided in a *setting* that is for "handicapped" people only.

"Treatment" services or, as they sometimes are called for people with developmental disabilities, "habilitation" services, are, in their elements: teaching and learning services; job training or retraining; recreation; companionship, sometimes homemaker services; "case management," housing and food. None of these services<sup>21</sup> is peculiar to disabled people. Similar services are regularly provided by government to others -- albeit without exacting the isolation and surrender of freedoms entailed by institutional segregation.<sup>22</sup>

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<sup>21</sup> Nothing here is to suggest anything about the quality of institutionalized "services." Amici's experience and the findings of every trial court (except one) before whom a record of institutional life has been made during the last three decades are that life there is nasty and brutish and "services" problematical.

<sup>22</sup> For example, respectively: the public schools, adult education, community colleges, job training, retraining, employment development and job referral services (see virtually all of Title 29, United States Code); municipal recreation programs and parks, state parks, national parks, companionship and homemaker services, e.g., under Title XIX of the Social Security Act, 42 U.S.C. §1396d(a)(7), or to elders under Medicare or the Area Agency on Aging Act, Title 42 U.S.C. ch. 35A; case management services under Title XIX, 42 U.S.C. §§1396d(a) & 1396n(g)(2); Section 8 housing, public housing, housing vouchers, 42 U.S.C. ch. 8; and food stamps, surplus food

Medical and dental services are provided alike to people with disabilities and those without disabilities under Medicare or Medical Assistance, including pharmaceuticals and psychotropic medicines, mobility and communication devices, the therapies, and rehabilitation services. See e.g. Title XIX, 42 U.S.C. §1396d(a)(11)(12)(13). So are public utilities, police and firefighting services, and protective services for people at risk of being hurt or harmed by others.

Unnecessary segregation into institutions excludes people with disabilities from receiving these services -- different from those received by non-disabled people only by a reasonable accommodation and frequently requiring no accommodation at all -- in the community as do all other citizens. The nature of the services to people with disabilities themselves is *not* mysterious, arcane, peculiar, or, in any meaningful use of the word unique to disabled people. Like those non-disabled people, the needs of people with disabilities can usually be met with services deliverable, and delivered, in the community. Wherever that is so and a state has undertaken to provide those services, they must under the Act be provided in the most integrated setting.<sup>23</sup>

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distributions, school breakfast, school lunch, and Summer food programs, 7 U.S.C. §§1431, 2011 *et seq.*; 42 U.S.C. §1751. In federally funded community-based services the person typically pays for "room and board," either from SSI payments, which are *not* available to persons in public institutions, or from wages. See II.D. *infra*.

<sup>23</sup> In this Act "solely" was removed from the phrase "by reason of such disability" not merely to "avoid unanticipated results," Pet.Br. at 29, but, as the Committee says on that same page, that "the existence of non-disability factors in a ... decision does not immunize [it]," that "the fact that the covered entity lists a number of factors for the [discrimination], in addition to the disability is not dispositive." H.R.Rep. 101-485 (II) at 84, 1990 U.S.C.C.A.N. Thus, state decisions unnecessary to segregate may not be insulated from the Act's prohibition by assertions of administrative or fiscal convenience or "tradition."

Burden is not undue, the House Judiciary Committee instructs, if, considering all "available," resources it is "only a small part of the overall budget of the state agency" and "slight compared to the societal consequences." H.R.Rep. (II) at 51; 1990 U.S.C.C.A.N. at 474. See Argument

### C. Section 504 Had Been Held by Courts to Prohibit Unnecessary Segregation.

The Act explicitly requires that "nothing in [it] shall be construed to apply a lesser standard than the standards applied under Title V of the Rehabilitation Act ... or the regulations issued [thereunder]." 42 U.S.C. §12201.

As to construction and application of Section 504 by federal courts to prohibit unnecessary segregation in institutions or nursing homes and to require that services be provided in the most integrated setting consistent with the needs of individuals with disabilities, Petitioners assert: "None did." Br. at 26. Petitioners are wrong.

First, they must reckon with the plain statement by the Court in Alexander v. Choate of "the statutory rights of the handicapped to be integrated into society." 469 U.S. at 300. Second, many lower courts did so construe and apply Section 504. Not all did. Indeed, part of the Congressional recognition in the late 1980's that then current laws were "inadequate" to combat "the pervasive problems of discrimination that people with disabilities are facing" was, as the Third Circuit has noted, that Section 504 had been given "erratic judicial interpretations." Helen L. v. DiDario, 46 F.3d 325, 331 (1995), *cert.den. sub.nom. Pa. Sec. of Pub. Welfare v. Idell S.*, 516 U.S. 813 (1995).

Among the judicial decisions which have so construed and applied Section 504 are: Lynch v. Maher, 507 F.Supp. 1268, 1278-1280 (D.Conn. 1981)(nursing home); Garrity v. Gallen, 522 F.Supp. 171 (D.N.H. 1981)(institution); Homeward Bound v. Hissom Mem. Center, 1987 WL 27104 at \*19 (N.D.Okla)(institution); Jackson v. Fort Stanton Hosp. and Training Sch., 757 F.Supp. 1243, 1296-1299 (D.N.M. 1988) (institution) *rev'd in part on other grounds*, 964 F.2d 980 (10th Cir. 1992); Bogard v. Duffy, C.A. No. 88-C-2424, Opin. of May 4, 1990 (N.D.Ill.)(nursing homes); Richard C. v.

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II.D. *infra*.



White, C.A. No. 89-2038, Opin. of Oct. 3, 1991 (W.D.Pa.) (institution).

In addition, in Halderman v. Pennhurst State School and Hospital, the district court rested its initial decision in part in Section 504, 446 F.Supp. 1295, 1321-24 (E.D.Pa. 1978), approved a settlement based in part thereon, 610 F.Supp. 1221, 1225 (1985), denied a Rule 60 Motion in part thereon, 784 F.Supp. 215, 224 (1992) *aff'd*, 977 F.2d 568 (3d Cir. 1992). The court of appeals spoke to 504 also at 612 F.2d 84, 107-08 & n.30 (3d Cir. 1979). See also NYSARC v. Carey, 551 F.Supp. 1165, 1184-1185 (E.D.N.Y. 1982); Lloyd v. Transit Auth., 548 F.2d 1277, 1284 n.20 (7th Cir. 1976).

Lynch v. Maher, *supra* (1981) limns exactly the holding in Helen L., *supra* (1995). The Lynch court denied a motion to dismiss and for summary judgment and granted a preliminary injunction requiring Connecticut to provide home care rather than "care in an institution" for a 35-year old quadriplegic man<sup>24</sup>.

"Section 504 prohibits unnecessarily segregated services for retarded persons" the court held in Hissom Mem. Center, 1987 WL 27104 at \*\*20-21, and ordered that services be

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<sup>24</sup> Garrity v. Gallen, 522 F.Supp. 171, 213-218 (D.N.H. 1981) *appealed and aff'd on other grounds*, 697 F.2d 452 (1st Cir. 1983) rejected an argument that 504 requires deinstitutionalization *per se* and forbids segregation *per se*, but held, at 214 that the State violated 504 because

Defendants have often made placements and disbursed services based not on an individual assessment of the abilities and potentials of each resident but on the generalized assumption that certain groups of people (e.g., profoundly retarded or non-ambulatory people) are unable to benefit from certain activities and services. This kind of blanket discrimination against the handicapped, and especially against the most severely handicapped, is unfortunately firmly rooted in the history of our country, and more particularly in the history of Laconia State School.

The court, at 215, further held:

As a final example of the discrimination practiced at LSS against the severely retarded, we note that until recently only the mildly and moderately retarded were considered for community placement, although the evidence at trial convinced the Court that severely and profoundly retarded individuals are capable of benefitting from such placements.

provided in integrated community settings for all residents of the Hissom Center whose needs could be met there. Before any transfer of services and persons from "segregated settings" to "more integrated settings" (at \*21), the court required "individual assessment ... of the appropriateness of the new environment" (at \*22). "The underdevelopment of a community services system," the Hissom court found (at \*21), "constitutes a continuation of the original and continuing discrimination practiced by the State against retarded people." Subsequently in an unpublished opinion (C.A. No. 85-C-437-E, May 20, 1988) at 67-70, 72 the court denied a stay, and reaffirmed its 504 holding.

In Jackson v. Fort Stanton Hosp. and Training Sch., *supra* at 1297, 1299, the court first acknowledged "that Section 504 does not afford ... an affirmative right to placement in a residential, non-institutional facility" as such and "does not prohibit the existence of separate services" as such (*see* Argument II. A. above), but, to the point, held

that the law is violated when certain residents of [Fort Stanton] are excluded from qualitatively different facilities which are being provided to their less severely handicapped peers, despite determinations that particular severely handicapped residents *can* live in community settings if defendants make reasonable accommodations in those settings. Where reasonable accommodations in community programs can be made, *defendants' failure to integrate severely handicapped residents into community programs which presently serve less severely handicapped residents violates §504*. *Id.* at 1299. (emphases supplied)<sup>25</sup>

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<sup>25</sup> Traynor v. Turnage, 485 U.S. 535, 549 (1998), stands only for the proposition that *justified* differentiation between "categories of handicapped people" withstands Section 504. Unjustified differentiation, however, falls, as it did in Fort Stanton. See regulation under Act prohibiting discrimination between "any class of individuals with disabilities." 28 C.F.R. § 35.130(b)(1)(iv). In Fort Stanton, since the needs of the particular residents could be met in the community, the differentiation was unjustified, and

In a previous, unpublished opinion denying a motion to dismiss (Civ. No. 87-0839 JP, *October 5, 1988* at 6), the Fort Stanton court had held:

while Section 504 does not affirmatively mandate deinstitutionalization for all mentally handicapped residents of state institutions, Section 504 prohibits placing [or keeping] mentally retarded persons in institutions based on stereotypical general opinions about the needs or abilities of that class of persons. 'The Rehabilitation Act forbids discrimination based on stereotypes about a handicap, but it does not forbid decisions based on the actual attributes of a handicap.'

In a phrase, Section 504 prevents *unnecessary* segregation.

In Bogard v. Kustra, C.A. No. 88-2414, May 4, 1990 (N.D. Ill.) at 26-29, the court sustained, against a motion to dismiss, a 504 claim by developmentally disabled persons whose needs could be met in community settings based upon generalized assumptions about their handicaps. In Richard C. v. White, C.A. No. 89-2038, October 3, 1991 (W.D. Pa.) at 3, 7 the court sustained against a motion to dismiss a 504 claim challenging defendants' "policies of segregation" which included "failure to" provide community services "to [institutionalized persons] not in need of institutionalization."

In ARC v. Sinner, (D.N.D., C.A.No. A1-80-141, April 29, 1992, at 6-7) after the appeals court on authority of *Pennhurst II* had set aside previous relief based in state law, 942 F.2d 1235 (8th Cir. 1991), the district court rested its decision prohibiting unnecessary segregation on 504. In Ky. ARC v. Conn, the district court similarly found Section 504 to prohibit institutionalization when a person's individual treatment team decided segregation was unnecessary. 510 F. Supp. 1233, 1249-50 (W.D.Ky 1980), *aff'd*, 674 F.2d 582 (6th Cir. 1982), *cert. denied*, 459 U.S. 1041 (1982).

Far from "none," these court decisions, many of them well known to the Congress, did construe and apply Section 504 to

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defendants' failure to integrate them was held to violate 504.

prohibit unnecessary segregation. However diverse other courts may variously have construed or applied Section 504, the Act was formulated in part to resolve such varying construction. See 135 Cong. Rec. S4986 (May 9, 1989) (Harkin) ("ensure once and for all that no Federal agency or judge will ever misconstrue the congressional mandate to integrate people with disabilities into the mainstream"). By its clear instruction, the Act Legislates a one-way ratchet: "nothing in this [Act] shall be construed to apply a lesser standard than the standards applied under Title V ... or [its] regulations." "Section 504," the Judiciary Committee Report found, "has served not only to open up public services and programs to people with disabilities, but *has also been used to end segregation.*" H.R.Rep. 101-485(III) at 49; 1990 U.S.C.C.A.N. at 472 (emphasis supplied).

**D. The Medical Assistance Statute Is in No Way Contrary to the Act, But Itself Contains a Parallel Prohibition on Unnecessary Utilization of Institutions and Nursing Homes and Provides Substantial Federal Funds for Services Provided in Integrated, Community Settings.**

Petitioners write about Title XIX of the Social Security Act (the medical assistance program) as if it were contrary to the Americans with Disabilities Act. Br. at 30-32. It is not. Rather, in independent provisions entirely consistent with the Act, Title XIX itself prohibits "*unnecessary utilization*" of the services thereunder. 42 U.S.C. §1396a(a)(30)(A). Furthermore, with pointed particularity, Title XIX also requires that "admission[s] to a hospital, intermediate care facility for the mentally retarded (ICF/MR) or hospital for mental diseases" be independently reviewed and evaluated. *Id.* at §1396a(a)(30)(B). With an exacting specificity, Title XIX expressly requires, and uniquely as to ICF/MRs, both "prior to admission or authorization of benefits in such facility" and "periodically," state and independent "review [of each



person's] need for such services. §1396a(a)(31). The regulation thereunder provides, for example, that for each person "whose needs could be met by alternative services that are currently unavailable, the facility must ... look for alternative services." 42 C.F.R. §456.371.

These provisions, enacted just two years into Title XIX were intended to "provid[e] suitable alternatives to institutional care." 113 Cong.Rec. 11417 (1967). The chief sponsor explained, "Federal medical assistance programs have been criticized... for emphasizing institutional services to the extent that a bias is produced tending to promote institutional confinement." *Id.* at 1416. The Committee Report stressed "assuring that patients are receiving appropriate care in an appropriate setting -- frequently in a lower cost facility or setting." S.Rep. No. 744, 90th Cong., 2nd Sess. (1967), 1967 U.S.C.C.A.N. 2866, 3029.

This prohibition on unnecessary institutionalization has been enforced in Homeward Bound v. Hissom Mem. Center, 1987 WL 27104 at \*18-19 (N.D.Okla), as well as its Opinion of May 1988, No. 85-CV-437-E, 67-70, and Jackson v. Fort Stanton Hosp. and Training Sch., No. 87-839, Opin. of October 5, 1988, commented on in final opinion, 757 F.Supp. at 1299-1302, 1315-17 (D.N.M. 1990), Bogard v. Duffy, N.D.Ill., No. 88-C-2424, Opin. of May 4, 1990; Richard C. v. White, No. 89-2038, Opin. of October 3, 1991 (W.D. Pa.); and Messier v. Southbury Training Sch., 916 F.Supp. 133, 142-146 (D.Conn. 1996).

When states in accordance with Title XIX "must look for alternative services," *supra*, they are not far to find. They are right at hand in the very same Title XIX. For persons with retardation or other developmental disabilities as well as for persons with chronic mental illness or other disabilities, Title XIX has provided since 1981 for home and community based services. To wit, 42 U.S.C. §1396n(c):

The Secretary may by waiver provide that a State plan approved under Title XIX ... may include ... the cost of home or community-based services (other than room and

board) ... which are provided pursuant to a written plan of care to individuals [as] to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or an intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.<sup>26</sup>

It is under this provision that Respondents are now being served by Georgia in the most integrated setting appropriate to their needs, rather than being unnecessarily segregated.<sup>27</sup>

Title XIX home and community based services must be "cost-effective," i.e., the *average* per person cost of the community-based services can not exceed the *average* cost of institutional services for which the participants would be

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<sup>26</sup> Georgia's federal medical assistance percentage reimbursement rate is 61.9%. For Mississippi, it is 78.1%; Montana, 64.4%; Indiana, 64%; Texas, 62.3%; Wyoming 59.7%; Colorado, 52.4%; for, South Carolina 70.8%; and Hawaii, 50%. MEDICAID STATE REPORTS -- FY 1996 (American Academy of Pediatrics, 1998).

<sup>27</sup> In 1996, when this case was before the district court, Georgia had *approved* but *unused* Title XIX authority for and home community based services to 763 people with disabilities who were then segregated in Georgia's institutions. U.S. H.C.F.A., Ga. Compliance Review, Home and Community-Based Waiver Program (June, 1996), in the district court record at R-79.

In 1996, Georgia's per capita federal home and community-based spending was less than half the national average. In 1996 Georgia ranked 50th in the country, ahead of Mississippi, in the number of people with retardation or other developmental disabilities served in community residential settings on a per capita basis (per citizen in general population).

In 1996, Georgia was 9th highest in percentage of total residential placements in congregate facilities. Its per capita nursing home utilization rate for retarded and other developmentally disable people was nearly twice the national average and 10th highest in the nation. Georgia was *one of only 7* states spending more on institutional "services" than on services in the community. BRADDOCK at 173-180 (Georgia) and *passim* (5th Ed. 1998).

eligible.<sup>28</sup> Nor is it necessary that a State "retire" an institutional bed for each community place created, or even that a state have *any* institutional beds. It is enough that the average cost of the community services not exceed the average cost of institutional "services," if the state provided any. The "cold bed" rule was eliminated in practice in 1991 and by regulation in 1994. "With [its] elimination a state may self-determine the number of individuals with disabilities it will service in its home and community based services program." Under Title XIX, the federal government will approve whatever number a state requests, and will provide federal reimbursement therefor. NATIONAL ASS'N OF STATE DIRECTORS OF DEVELOPMENTAL DISABILITIES SERVS., THE HCB WAIVER AND CSLA PROGRAM at 83 & B-9 (1994).

In Georgia, the district court found, on average, institution costs per person are twice community costs. 1997 U.S. Dist. LEXIS 3540, at \*12 n.4 (N.D. Ga. March 25, 1997). The cost ratio, similar in all states, is set forth in Appendix F. Georgia can secure authorization and federal reimbursement at 61.9% of cost, for as many community-based placements as they elect to provide persons like L.C. and E.W., whom Georgia now unnecessarily segregates in violation of the Act.

### III. For Amici, the Act Has Been a Doorway to Freedom, Citizenship, and Productive, Participating, and Contributing New Lives.

The results of formerly institutionalized people with disabilities moving into integrated community settings have been profoundly affirmative. Congress expected that "while the integration of people with disabilities will sometimes involve substantial short-term burdens, both financial and

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<sup>28</sup> Needing the "level of care" that an institutional facility provides does *not* mean the person's needs can only be met in the segregated institutional setting or even that they will be met there. As the statute plainly affirms, a needed level of care can be provided in home or community based settings.

administrative, the long-range effects of integration will benefit society." H.R. Rep. 101-336 (II) at 50.

Both the personal experience of former institution residents<sup>29</sup> and meticulously documented, longitudinal studies of the experience, before and after, of people who left institutions and moved into communities show: there is significant growth along every dimension of skill; the people with the most severe disabilities gain the most; gainful employment increases significantly, as does income; actual interaction between people with and without disabilities and religious and civil participation grow enormously.

To illustrate, an Oklahoma study of 382 former residents of the Hissom Center concluded their "enhancements in life style and quality have been dramatic" once in the community. Conroy *et al.*, THE HISSOM OUTCOMES STUDY: A REPORT ON SIX YEARS OF MOVEMENT INTO SUPPORTED LIVING 64 (1995). Similar longitudinal studies around the country, *cited in* Appendix D, show respectively that moving into the community significantly increased people's involvement with their families, development, and employment and educational experiences.

Illustratively, in an article co-authored by Amici Self-Advocates,<sup>30</sup> former institution residents from across the country clearly articulated the inseverable bond between community integration and Congress' goals in the Act:

Well, what is it like to live in the community? ... You don't feel like you're an animal in a cage. You can go see a play and movie and go to the shopping centers ... You feel more independent, like you're useful.

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<sup>29</sup> In 1996, 199,890 people with developmental disabilities lived in 1 to 6 person homes and received Title XIX-funded services in integrated settings. In 1996 59,726 lived segregated into public institutions (down from some 228,000 in 1969) and 38,438 in nursing homes. BRADDOCK at 24-27.

<sup>30</sup> As to self-expressed, self-reported experiences of people with disabilities, *see* Appendix C for a bibliography of speaking for ourselves publications and *see* Appendix D for findings of people with disabilities.



Another person stated:

I enjoy working as a janitor five days a week. I enjoy working [at one place] better because of pay and benefits. I am now looking for a roommate to be friends with and share the expenses.

STORIES FROM THE BELLY OF THE BEAST: TESTIMONY FROM SURVIVORS OF INSTITUTIONALIZATION 18-22 (Sept. 23, 1996). See also *Impact* (Vols. 1-12), a publication of the Center for Community Integration. The pride with which former institution residents describe seemingly mundane activities most others take for granted betrays the harsh and debilitating effects of unnecessary segregation. Perhaps the shortest statement is also the most descriptive: one former institution resident said simply, "I like my freedom." *Id.* at 18.

### CONCLUSION

John W. Davis, counsel to South Carolina, opened Argument in *Brown v. Board of Education*, saying:

May it please the Court, I think if the appellants' construction of the Fourteenth Amendment should prevail here ... , I am unable to see why a state would have any further right to segregate ... on the ground of sex or on the ground of age or on the ground of mental capacity.

ARGUMENT 51 (1989). Rooted in the Equal Protection Clause and a thoughtful understanding of disabilities and history, the Congress has acted to prohibit the unnecessary segregation of people with disabilities. For all of the above-stated reasons, Amici respectfully request the Court affirm the judgment of the 11th Circuit in favor of Respondents.

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## **APPENDICES**



## **APPENDIX A**

## APPENDIX A

### COMPENDIUM OF PURPOSEFUL STATE ACTION FOR THE SEGREGATION AND EXCLUSION OF RETARDED PERSONS IN THE FIFTY STATES AND THE DISTRICT OF COLUMBIA

This Appendix presents the official actions of the states promoting and requiring by statute the segregation of retarded people.\* Amici have included a sampling of state reports of agencies, officials, committees and boards that constitute the legislative history and the post-enactment history of the laws that were adopted.\*\* All italics have been added by amici.

#### CONTENTS

|                           | Page |
|---------------------------|------|
| Northeastern States ..... | A-1  |
| Connecticut .....         | A-1  |
| Delaware .....            | A-4  |
| Maine .....               | A-5  |
| Maryland .....            | A-5  |
| Massachusetts .....       | A-6  |
| New Hampshire .....       | A-9  |
| New Jersey .....          | A-10 |
| New York .....            | A-12 |
| Pennsylvania .....        | A-18 |

\*In addition to the 50 states, the federal law enacted by the United States Congress to segregate retarded people found in the District of Columbia is set out at A-76-81.

\*\*For a sampling of state actions affecting retarded people in other areas, *e.g.*, restrictions on marriage, voting, and education, see Appendix B to the Amici Brief of the American Association of Mental Deficiency, *et al.*



# CONTENTS—(Continued)

|                                | Page |
|--------------------------------|------|
| Rhode Island.....              | A-20 |
| Vermont.....                   | A-21 |
| <b>Midwestern States</b> ..... | A-22 |
| Illinois.....                  | A-22 |
| Indiana.....                   | A-22 |
| Iowa.....                      | A-25 |
| Kansas.....                    | A-26 |
| Kentucky.....                  | A-29 |
| Michigan.....                  | A-29 |
| Minnesota.....                 | A-32 |
| Missouri.....                  | A-32 |
| Nebraska.....                  | A-33 |
| North Dakota.....              | A-35 |
| Ohio.....                      | A-36 |
| South Dakota.....              | A-37 |
| Wisconsin.....                 | A-42 |
| <b>Southern States</b> .....   | A-44 |
| Alabama.....                   | A-44 |
| Arkansas.....                  | A-45 |
| Florida.....                   | A-45 |
| Georgia.....                   | A-45 |
| Louisiana.....                 | A-46 |
| Mississippi.....               | A-47 |
| North Carolina.....            | A-48 |

# CONTENTS—(Continued)

|                                   | Page |
|-----------------------------------|------|
| Oklahoma.....                     | A-49 |
| South Carolina.....               | A-50 |
| Tennessee.....                    | A-51 |
| Texas.....                        | A-52 |
| Virginia.....                     | A-57 |
| West Virginia.....                | A-60 |
| <b>Western States</b> .....       | A-61 |
| Alaska.....                       | A-61 |
| Arizona.....                      | A-61 |
| California.....                   | A-62 |
| Colorado.....                     | A-67 |
| Hawaii.....                       | A-68 |
| Idaho.....                        | A-68 |
| Montana.....                      | A-69 |
| Nevada.....                       | A-70 |
| New Mexico.....                   | A-70 |
| Oregon.....                       | A-70 |
| Utah.....                         | A-72 |
| Washington.....                   | A-73 |
| Wyoming.....                      | A-75 |
| <b>District of Columbia</b> ..... | A-76 |

## Northeastern States

**Connecticut.** The first recorded provision of a specialized facility for retarded people in this country occurred in Connecticut when the American Asylum for the Deaf and Dumb, located in Hartford, in 1818 counted among its students a few "idiot children." REPORT OF THE COMMISSIONERS ON IDIOCY TO THE GENERAL ASSEMBLY OF CONNECTICUT 62 (1856). Later, the Connecticut legislature provided some funding for a private school in Lakeville. After the turn of the century, though, that facility began receiving a sharply increased number of residents, and it soon became a custodial institution. In 1906 the Director was already reporting that "removals are almost unknown." REPORT OF THE DIRECTORS AND SUPERINTENDENT OF THE CONNECTICUT SCHOOL FOR IMBECILES 6 (1906).

By 1908 the operators of the facility claimed they had "a wide knowledge of the imperative need of providing *permanent* custodial care for the safeguarding of girls and women of feeble mind, and a growing appreciation of the preventive value of equal custodial care for the male of evil tendencies. Backed by effective legislation the care of the defective has resolved itself into a comparatively simply matter. . . ." REPORT OF THE DIRECTORS AND SUPERINTENDENT OF THE CONNECTICUT SCHOOL FOR IMBECILES 12 (1908). "[T]he surest, most humane and most economical solution of the problem of prevention lies in providing custodial care for the feeble minded of every condition and *for a lifetime*." *Id.* at 13.

In 1911, the General Assembly enacted a statute providing that "imbecile[s]" could be admitted to the Lakeville facility by application of the "selectmen" of any town. 1911 Conn. Pub. Acts 1493, ch. 211. In 1913 the state formally took control of the institution by enactment of a statute specifying that its "object" would henceforth be the "custody" of any "imbeciles resident of this state." 1913 Conn. Pub. Acts 1765, ch. 160, § 1.



The following year, state officials reported that they were "of the opinion that the problem of the feeble-minded in the State of Connecticut urgently demands a much more adequate provision for these unfortunate individuals than is now supplied. It has been estimated that *there must be at least three thousand feeble-minded in the State, and at the present time, provision is made for only three hundred.* It is a now recognized fact that feeble-mindedness is to a much greater extent than insanity an inheritable condition and it is known that this class is particularly prolific. The criminal, the alcoholic, and the prostitute are all recruited from the ranks of the feeble-minded. The only practicable way to restrict the growth of the feeble-mindedness in the state is to *segregate* the feeble minded and particularly feeble-minded women during the child bearing-period. The question to be decided is really this: Shall we of this generation accept the burden of this care, or shall we hand on to the next generation a much larger share? Undoubtedly failure to *now segregate* the feeble-minded will result in an increasing prevalence of the condition as time goes on." STATE OF CONNECTICUT, BIENNIAL REPORT OF CONNECTICUT SCHOOL FOR IMBECILES, LAKEVILLE, CONN., FOR TWO YEARS ENDED SEPTEMBER 30, 1913-14, at 8 (Pub. Doc. No. 15, 1915). The report also recommended that the "institution should not be situated in the midst of a populous village. While it should be convenient to railroad communication, it should be somewhat *remote from the centers of population for reasons that are obvious.*" *Id.* at 7.

In order to gain public support for the new facility, Superintendent Charles T. LaMoure and the Board of Trustees of the School for Imbeciles published and distributed widely a pamphlet in which they claimed an urgent need to "[s]top the supply of the vicious, the weak, the no-willed people who cannot support themselves in the community — of the criminals and prostitutes and paupers, by cutting off the supply at its source, namely

— by providing adequate *custodial care for the feeble-minded of the State.*" THE CONN. SCHOOL FOR IMBECILES, THE MENACE OF THE FEEBLE-MINDED IN CONNECTICUT 9 (1915). These "feeble-minded" people, "though really children, are *allowed to go about through the community as though they were adults.* They have an impaired sense of right and wrong, weak will power and no power of realizing the future. . . .

"Moreover, the feeble-minded are unusually prolific. Therefore the longer the State of Connecticut delays in making adequate provision for the feeble-minded, the greater the burden of feeble-mindedness she will have to bear in future [*sic*]." *Id.* at 3. But they proposed a solution: "The State has the opportunity of buying for this institution a large tract of forest and arable land — between six and seven hundred acres. . . . This property is in the central part of the State, *remote from centres of population* . . . and there is room for the institution to grow indefinitely." *Id.* at 13. For this purpose, "[t]he trustees of the Connecticut School for Imbeciles are asking the General Assembly for authority to sell the present plant, and to use the proceeds and \$200,000 to be appropriated by the State in the purchase of this property, and in equipping it for the needs of the institution. This would provide, aside from the necessary alterations to buildings, etc., sufficient cattle and farming implements, so that the institution could produce its own milk and vegetables, *using for the most part the labor of its high grade patients.*" *Id.* at 14.

On February 25, 1915, a hearing was held before the state legislature's Committee on Humane Institutions. One witness testified that "hardly a week goes by but what we have a case of a feeble-minded girl or boy called to our attention. We have no way of *getting rid of* these kinds of cases." *Connecticut School for Imbeciles: Hearings on H. B. No. 644 Before the Joint Standing Committee on Humane Institutions* 20 (typed transcript, Feb. 25, 1915) (statement of Mr. Kerner of Waterbury). An-

other thought it necessary for "every feeble-minded child in the school [to be] eliminated or placed in a special class." *Id.* (statement of Miss Wright of Stanford). Superintendent Alexander Johnson of New Jersey's institution at Vineland brought to the Committee's attention "this book called, 'The Menace of the Feeble-Minded in Connecticut,' which was gotten up by the Board of Trustees for the School of Imbeciles, and I would recommend anyone who has any doubt as to the proper care of that class to read this book very carefully." *Id.* at 2 (statement of Dr. Johnson).

On May 20, 1915, the Connecticut legislature followed the recommendations of the state officials and the witnesses at the hearing and appropriated the \$200,000 requested for an ambitious construction project on state-owned land at Mansfield Depot, an isolated railway stop sixty miles northeast of Hartford.

By the time he wrote his 1916 Biennial Report, Superintendent LaMoure thought that "[t]he dangers associated with allowing the feeble-minded to remain at large among the general population have been so frequently discussed that it is not necessary to do more than refer to them." STATE OF CONNECTICUT, BIENNIAL REPORT OF THE CONNECTICUT TRAINING SCHOOL FOR FEEBLE-MINDED, LAKEVILLE, CONN., FOR THE TWO YEARS ENDED SEPTEMBER 30, 1915-16, at 7 (Pub. Doc. No. 15, 1917). He looked forward to the completion of the new institution, where, he noted, "[m]any of the male inmates . . . are capable of doing a considerable amount of satisfactory farm work under supervision, and, with a proper farm we should be in a position to improve the quality of our food and save the State a considerable amount of money by raising vegetables, producing our own milk and eggs, and using rather than wasting our garbage by the keeping of pigs." *Id.*

**Delaware.** On March 21, 1917, the Delaware General Assembly established the state's first home for "the feeble-minded." 1917 Del. Laws 597, ch. 172. The in-

stitutionalization of such persons could be sought by "any reputable citizen of the State," which was to be ordered by the county judge "when by reason of such mental condition, or of existing social conditions, it would be detrimental to any community of this State to allow such person to remain at large." *Id.* §9.

The legislature also adopted "AN ACT to provide for the sterilization of certain mental defectives," 1923 Del. Laws, ch. 62, authorizing the surgery for those at the state home for whom a "physician, alienist and superintendent unanimously determine that procreation is *unadvisable*." *Id.*

**Maine.** In 1907, the Legislature of Maine established the "Maine School for Feeble Minded." 1907 Me. Acts 42, ch. 44. A special committee chaired by Governor William T. Cobb "[a]fter careful consideration," located the institution "on an area of farmland. . . . The plan called for a large tract of land, which should be removed from any large town. . . ." Hood, *Pineland Observer*, in PINELANDS, 60 YEARS: 1908-1968 (L. Moore, ed. 1968).

In 1921, the lawmakers extended those eligible for commitment to "idiotic and feeble-minded males, between the ages of six years and forty years, and females, between the ages of six years and forty-five years." 1921 Me. Acts 65, ch. 60. Four years later, the legislature authorized sterilization for all those for whom that surgery "may be indicated for the prevention of the reproduction of further feeble-mindedness." 1925 Me. Acts 198, ch. 208.

**Maryland.** On March 31, 1888, the General Assembly of Maryland passed "AN ACT to establish an asylum and training school for the feeble minded of the State of Maryland." 1888 Md. Laws 268, ch. 183. In 1906, the lawmakers mandated that the institution "receive, care for and educate, free of charge, all idiotic, imbecile and feeble-minded persons in this state" approved by the board of visitors of the facility. 1906 Md. Laws 653, ch. 362. The law required that "all such persons shall re-



main in the care, custody and control of the visitors of said institution, and the visitors of said institution are hereby authorized to *retain all such persons* in their care, custody and control at said institution, until such time as in the judgment of said visitors, or a majority of them, the welfare of such persons *and the public interest* shall justify or call for their release. . . ." *Id.* at 653-54.

The Board of Visitors campaigned vigorously for increased admissions. These reports revealed the institution's segregating purposes: "One of the sad features which hangs as a black cloud over the work, is the fact that some hundreds of children, many of whom are *a burden to the family and a menace to the community in which they live*, are continuously knocking at our doors for admission, but only a small number of these can be received solely for want of funds to maintain them, though we have empty beds awaiting their reception." TWENTY-FOURTH REPORT OF THE BOARD OF VISITORS OF THE ROSEWOOD STATE TRAINING SCHOOL, OWINGS MILLS, BALTIMORE COUNTY 5 (1936).

**Massachusetts.** As a result of a legislatively commissioned report authored by Dr. Samuel Gridley Howe of the Harvard Medical School, S. G. HOWE, FIRST COMPLETE REPORT MADE TO THE LEGISLATURE OF MASSACHUSETTS UPON IDIOCY 16, 30-55 (Mass. Sen. Doc. No. 51, 1848), the Massachusetts legislature, on May 8, 1848 appropriated \$2,500 for an experimental school for idiotic children to be located in a wing of the Perkins Institute for the Blind in Boston. Howe was named director, and ten indigent "idiots" were selected as pupils. THIRD AND FINAL REPORT ON THE EXPERIMENTAL SCHOOL FOR TEACHING AND TRAINING IDIOTIC CHILDREN 305 (1852).

With perhaps a premonition of the evils that lurked in his creation, Howe stated in his final report: "Now the danger of misdirection in this pious and benevolent work is, that two false principles may be incorporated with the projected institutions which will be as rotten piles in the

foundations and make the future establishments deplorably defective and mischievous. These are, first, close congregation; and, second, the life-long association of a large number of idiots; whereas, the true, sound principles are: separation of idiots from each other; and then diffusion among the normal population. . . . For these and other reasons it is unwise to organize establishments for teaching and training idiotic children, upon such principles as will tend to make them become asylums for life. . . . *Even idiots have rights* which should be carefully considered! At any rate let us try for something which shall not imply segregating the wards in classes, removing them from our sight and knowledge, ridding ourselves of our responsibility as neighbors, and leaving the wards closely packed in establishments where the spirit of pauperism is surely engendered, and the morbid peculiarities of each are intensified by constant and close association of others of his class." S. G. HOWE, REPORT OF THE SUPERINTENDENT TO THE TRUSTEES OF THE MASSACHUSETTS SCHOOL FOR IDIOTIC CHILDREN (1874).

Howe's advice was forgotten and, by 1886, the Massachusetts legislature had established "a custodial department" for "custody of feeble-minded persons beyond the school age or not capable of being benefited by school instruction." 1886 Mass. Acts & Resolves, ch. 298, §1. After the turn of the century, commitment procedures were modified to permit *any* person, not just relatives, to seek the commitment of "feeble-minded" persons to the institution. See 1904 Mass. Acts & Resolves, ch. 459, §5; 1906 Mass. Acts & Resolves, ch. 508, §12.

The superintendent of Massachusetts' institution, Dr. Walter E. Fernald, reported in 1908 that "[t]he existence of this large institution is largely due to the demands of parents, physicians, clergymen, court officers, social workers, and thoughtful people generally, that feeble-minded women should be *permanently removed from the community*. In this State there is an urgent de-

mand for the commitment and *permanent detention* of the higher grade cases of defect, where the social incapacity and the moral weakness are more obvious than the mental backwardness. These cases cannot support themselves, and *are most undesirable and troublesome members of society.*" SIXTY-FIRST ANNUAL REPORT OF THE TRUSTEES OF THE MASSACHUSETTS SCHOOL FOR THE FEEBLE-MINDED AT WALTHAM, FOR THE YEAR ENDING NOVEMBER 30, 1908, at 22-23 (1909).

On June 12, 1912, Superintendent Fernald delivered an influential speech as the Annual Discourse before the Massachusetts Medical Society, printed and widely distributed in pamphlet form by the Massachusetts Society for Mental Hygiene: "The past few years have witnessed a striking awakening of professional and popular consciousness of the widespread prevalence of feeble-mindedness and its influence as a source of wretchedness to the patient himself and to his family, and as a causative factor in the production of crime, prostitution, pauperism, illegitimacy, intemperance and other complex social diseases. . . . The social and economic burdens of uncomplicated feeble-mindedness are only too well known. The feeble-minded are *a parasitic, predatory class*, never capable of self-support or of managing their own affairs. The great majority ultimately become public charges in some form. *They cause unutterable sorrow at home and are a menace and danger to the community.* Feeble-minded women are almost invariably immoral, and if at large usually become carriers of venereal disease or give birth to children who are as defective as themselves. The feeble-minded woman who marries is twice as prolific as the normal woman. . . . [S]egregation carried out thoroughly for a generation would largely reduce the amount of feeble-mindedness. The high-grade female imbecile group is the most dangerous class. They are not capable of becoming desirable or safe members of the community. They are never able to support themselves. They are certain to become sexual offenders and

to spread venereal disease or to give birth to degenerate children. Their numerous progeny usually become public charges as diseased or neglected children, imbeciles, epileptics, juvenile delinquents or later on as adult paupers or criminals. The segregation of this class should be rapidly extended until all not adequately guarded at home are placed under strict sexual quarantine. Hundreds of known cases of this sort are now at large because the institutions are overcrowded. Only 2000 feeble-minded persons are now cared for in institutions in this State, and over 1000 applicants are awaiting admission to the institutions. There is an *urgent demand for greatly increased institutional provision* for this class. . . ." W. FERNALD, THE BURDEN OF FEEBLE-MINDEDNESS 3, 7, 10 (1912).

**New Hampshire.** On March 22, 1901, the New Hampshire General Court enacted legislative to "establish and maintain" the "New Hampshire School for the Feeble-minded Children." 1901 N.H. Laws 597, ch. 102, § 1. Although that law limited admissions to "the idiotic and feeble-minded, between three and twenty-one years of age," *id.*, amendments added four years later made provision for others "after they reach the age of twenty-one, if in the judgment of the board of trustees *their segregation seems to be for the best interests of the community.* . . ." 1905 N.H. Laws 413, ch. 23, § 1, first for women, *id.*, and later for men as well, 1917 N.H. Laws 645, ch. 141, § 1. Later, in 1917, the General Court adopted "AN ACT PERMITTING STERILIZING OPERATIONS" for those for whom that surgery "may be indicated for the prevention of the reproduction of further feeble-mindedness." 1917 N.H. Laws 704, ch. 181, § 2. In 1929, the law was extended to permit the superintendent of the institution, if "of opinion that it is for the best interests of the inmate *and of society*" to authorize the surgery without the consent of the "feeble-minded" resident, if after a hearing the governing board of the institution finds that the resident "is the probable potential parent of *socially*



*inadequate offspring likewise afflicted.*" 1929 N.H. Laws 162, 164, ch. 138, §§ 1, 6.

**New Jersey.** The New Jersey General Assembly in 1888 established the first New Jersey "home" for the "feeble-minded" at Vineland. 1888 N.J. Laws. 267, ch. 208.

By 1906, state officials were calling for permanent segregation: "It is a fact that the Institutions in New Jersey for the care and training of the feeble-minded do not begin in any way to cover the number of those who should be in the Institutions, and it seems that the Governor, the Legislature and the Commissioner of Charities in their wisdom might hold a conference with the Boards of the Feeble-Minded Institutions, looking towards *the segregation of all the feeble-minded who are now at large*. The feeble-minded belong to that class of defectives of either hereditary degenerates or whose condition is of such a character as should be treated like them, and for whom *the time has come for complete and permanent control.*" ANNUAL REPORT OF THE STATE HOME FOR THE CARE AND TRAINING OF FEEBLE-MINDED WOMEN AT VINELAND, 1906, at 6 (1907). The report indicated that "[t]he most celebrated authorities on the care and segregation of the feeble-minded and other defectives are very much in favor of *the colonization of all defectives* where the development of its members could be properly classified." *Id.* at 7.

The legislature began its response in 1911, by passing "An Act to authorize and provide for the sterilization of feeble-minded (including idiots, imbeciles and morons)." 1911 N.J. Laws 353, ch. 190. That law created a "Board of Examiners of Feeble-minded," which, upon a "find[ing] that procreation is inadvisable and that there is no probability that the condition of such inmate so examined will improve to such an extent as to render procreation by such inmate advisable," was authorized "to

perform such operation for the prevention of procreation as shall be decided by said board of examiners to be most effective. . . ." *Id.* §§ 1, 3.

Two years after its enactment, the New Jersey Supreme Court ruled that New Jersey's law violated the right to equal protection of the laws. *Smith v. Board of Examiners of Feeble-Minded*, 85 N.J.L. 46, 88 A. 963 (1913). The court noted that "the feeble-minded and epileptics are not the only persons in the community whose elimination as undesirable citizens would, or might in the judgment of the legislature, be a distinct benefit to society. . . . Racial differences, for instance, [also] might afford a basis for such an opinion in communities where that question is unfortunately a permanent and paramount issue." 88 A. at 965. The court concluded that "it is clear that the order with which we have to deal threatens possibly the life, and certainly the liberty, of the prosecutrix in a manner forbidden by both the state and federal Constitutions, unless such order is a valid exercise of the police power. . . . The general limitation of such power to which the prosecutrix must appeal is that under our system of government the artificial enhancement of the public welfare by the forceable suppression of the constitutional rights of the individual is inadmissible." *Id.* at 965.

In 1915, the legislature provided for more pervasive segregation of retarded people through the admission to Vineland of "mentally defective men, women and children, *of all ages and grades.* . . ." 1915 N.J. Laws 278, ch. 151, § 2. By 1918, the lawmakers had authorized "the location of additional colonies upon forest reserve or other lands owned by the State." 1918 N.J. Laws 410, ch. 147, art. 6 § 636. It was in these institutions that the "inmates" were to be "kept." *Id.* at 409, 410, §§ 631, 635. In 1919, the legislature required relatives "to *waive all right to remove either permanently or for a limited time*" their kin from any institution. 1919 N.J. Laws 508, ch. 217, § 3.

**New York.** On July 10, 1851, the Legislature of New York adopted "AN ACT to establish an asylum for idiots." 1851 N.Y. Laws 941, ch. 502.

It was not until 1894 that the New York legislature established an institution in Oneida County purely for the "custody of unteachable idiots," designated as "the Rome State Custodial Asylum." 1894 N.Y. Laws 806, ch. 382.

The movement to segregate began most earnestly at the same time as the citizenry began to express concern about the "rising tide" of immigration. In 1905, for example, an article in the *New York Times* typical of those appearing during this period discussed the urgent need for "remedying the evils which have too long been tolerated in the 'dumping' of undesirable immigrants into this country." *Undesirable Immigration*, N.Y. Times, Feb. 10, 1905, at 6, col. 3.

In 1911, the first of many studies purporting to link "feeble-mindedness" with the new immigration was published under the auspices of the State Charities Aid Association. The survey found that all but 40 of 317 "mentally defective" children selected "at random" from thirty-two ungraded classes in the New York public schools were either foreign-born or the children of foreign parents. A. MOORE, *THE FEEBLE-MINDED IN NEW YORK: A REPORT PREPARED FOR THE PUBLIC EDUCATION ASSOCIATION OF NEW YORK*, N.Y. (1911).

By 1912, the *New York Times* was reporting a definite link between immigration and "feeble-mindedness." An article appearing on February 18, 1912 quoted "[a]n important report of the special committee appointed by the New York Society for the Prevention of Cruelty to Children to investigate the subject of abnormal and feeble-minded children. . . ." *Feeble-Minded Scholars Make Up 1 Per Cent of the School Population*, *Investigators Report*, N.Y. Times, Feb. 18, 1912, at 8, col. 4. The report stated that there were in New York City "10,000 mental or moral defectives who now roam at large

in the community without any proper parental supervision or medical care. Recent census statistics show that 80 per cent of the feeble-minded children in the general population of the United States are the progeny of aliens or naturalized citizens. We may safely assume, therefore, that at least 8,000 of the 10,000 feeble-minded children in the city today were brought here by or are the offspring of the 9,000,000 aliens who have passed through Ellis Island during the past ten years." Quoted in *id.* at cols. 4-5.

Three weeks later, the *New York Times* featured an article on Henry H. Goddard, who was a state administrator for New Jersey's retardation institution at Vineland. The report began: "From the army of 300,000 feeble-minded persons in the United States come the recruits that swell the ranks of the drunkards, criminals, paupers, and other social outcasts. Twenty-five per cent of the girls and boys in our reformatories are lacking in mental fibre and are unable to discern the difference between right and wrong or are too weak in character to do right whenever there is any inducement to do wrong. Sixty-five per cent of the feeble-minded children have a mother or a father, or both, who are feeble-minded. This country has so far taken no steps to segregate these irresponsible parents, so the number of them is constantly increasing. These facts, and many more equally startling, are set forth in an article written for The Survey by Dr. Henry H. Stoddard, [sic] director of the department of research of the training school at Vineland, N.J. 'Our Government spends hundreds of thousands of dollars examining immigrants to see that none who are feeble-minded are admitted,' writes Dr. Stoddard [sic]; 'but here is a group already in our country who are breeding a race of feeble-minded people more dangerous than many barred by the Immigration Inspectors.'" *Weak-Minded Fill Ranks of Criminals: Dr. Henry Stoddard [sic] Says Social Problems Can Be Solved By Segregating Them*, N.Y. Times, Mar. 10, 1912, at 6, col. 3. Goddard urged, in language



later quoted in some state statutes, "permanent care where they will be happy and harmless," for all those "unable to compete with their fellows on equal terms. . . . This army furnishes the recruits for the ranks of the criminals, paupers, drunkards, the ne-er-do-wells, and others who are social misfits." *Quoted in id.* "[W]hat then is to be done?" he asked. Dr. Goddard answered his own question by proposing that "[a]fter these cases have been discovered they must be removed from the environment in which it has been proved *they are incapable of living normal lives in accordance with the conventions of society.* They must be colonized in groups where they may be perfectly happy and somewhat useful. Only one limitation needs be placed upon them in these places, and that is they must never become parents." *Quoted in id.* Goddard concluded by emphasizing that "[w]e are discussing a possible State policy . . . many parents are either normal or of such a high grade of defectiveness that they never get into court and yet have feeble-minded children. We cannot touch these adults. We must somehow get hold of their children. . . . We may reasonably hope that a policy of segregation, carefully followed, will in a generation or two largely reduce our feeble-minded population and thereby solve our problems of criminals, disease, drunkenness, and crime." *Quoted in id.* at cols. 3-4.

On April 16, 1912, the legislature created a new state board and empowered it to authorize the sterilization "by such operation for the prevention of procreation as shall be decided by said board to be most effective," "any" institutionalized person who, in the judgment of the board, "would produce children with an inherited *tendency*" to "feeble-mindedness, idiocy or imbecility." 1912 N.Y. Laws 924, 925, ch. 445, §351.

New York's special treatment of its "alien defectives" during this period is evidenced by the response state officials gave to a survey form sent to each state on June 20, 1912 by a Pennsylvania commission gathering information to assist the latter state in expanding its own in-

stitutions. New York's response indicated that the state already had nearly 6,000 citizens segregated, noting specially that it "contributes towards the support of the *alien* poor patients in these institutions." REPORT OF THE COMMISSION ON THE SEGREGATION, CARE AND TREATMENT OF FEEBLE-MINDED AND EPILEPTIC PERSONS IN THE COMMONWEALTH OF PENNSYLVANIA 28, 31 (1913). No other group was singled out by New York officials for special support.

It was also about this time that the newly reknowned Henry Goddard was invited by the United States Public Health Service to administer Binet's I.Q. test to the southern and eastern European immigrants arriving in steerage at Ellis Island. "[G]iv[ing] the immigrant the benefit of every doubt," he found that 79% of the Italians, 80% of the Hungarians, 83% of the Jews, and 87% of the Russians he tested were "feeble-minded." Goddard, *Mental Testing and the Immigrants*, 2 J. DELINQUENCY 243, 249, 252 (1917).

The *New York Times* reported in an article entitled *Alien Defectives* appearing on January 13, 1913 that since "three-tenths of feeble-minded children are of alien or naturalized parents, the problem of detecting defective immigrants is very grave." N.Y. Times, Jan. 13, 1913, at 10. The account cited a recommendation by Assistant Surgeon C. P. Knight of the United States Public Health Service at Ellis Island, writing in the January 11 issue of the *American Medical Association Journal*, for "controlling the procreation of the mentally defective by segregating them." *Alien Defectives, supra.* As Dr. Knight had stated, "[t]here is scarcely a ship coming into the Port of New York which does not carry among its passengers a mental defective of some degree." *Id., quoting Knight, The Detection of the Mentally Defective Among Immigrants*, 60 A.M.A.J. 106 (1913).

In the A.M.A. *Journal* article, Dr. Knight explained that he had "becom[e] familiar with different races" so he could "tell at a glance the abnormal from the normal."

*Id.* at 107. "In studying the physical characteristics of mental defectives, the various ethnologic types are easily discerned: the dark skin, the curly hair and thick lips of the Ethiopian, the prominent and high cheekbones and deep orbits of the American Indian and the straight coarse hair and peculiar cast of countenance of the Mongolian." *Id.* Even "more important in the determination of the mental status of the alien," according to Dr. Knight, was "close application to the study of the race." Thus, examiners "should interpret the mental reaction of the alien only after having full knowledge of the different racial characteristics, for that which is a defect in an individual of a race of high mental attainment may be a normal condition in the existence of other people who have not attained the same grade of development. It is perfectly normal for the southern Italian to show emotion on the slightest provocation but should he show the stolidity and indifference of the Pole or Russian, we would look on him with suspicion and perhaps hold him for a detailed examination." *Id.* By the use of such techniques, Knight hoped to "reduc[e] to a minimum the entrance into this country of the mentally and morally low type of alien. Immigration largely contributes to the high percentage of this class in the United States." *Id.* at 106.

By 1914, the "defectives" were being expelled from the public schools. As the *New York Times* editorialized: "If the policy recommended by the Board of Education's committee on ungraded classes had been sensibly adopted in the beginning a good deal of money might have been saved for teaching sound-minded children that has been wasted on mental defectives who could not be helped. The report says: 'Most imbeciles and all idiots can in no way derive any lasting benefits from attendance at the public schools. Their mental condition cannot be improved either by the course of study or discipline. The only practical and humane solution is institutional care.'" *The Feeble-Minded in Schools*, N.Y. Times, Mar. 13, 1914, at 8, col. 4.

That same year, as a result of the public demand for action, the legislature created a special State Commission to study the problem, as urged by the *New York Times*. 1914 N.Y. Laws 772, ch. 272.

The Commission believed that "we are now in a position where it is both a duty and a privilege to adopt a complete system of public provision that will in a very large measure eliminate the burden of feeble-mindedness from the community." *Id.* at 18.

Sterilization, according to the Commission, was no panacea, since surgery prevented only parenthood, and did not eliminate the other social menaces stemming from permitting "defectives" to be at large. Moreover, such a law might lead to "withdraw[al] from the influence of our institutions large numbers of feeble-minded who otherwise might be amenable to whatever advantages and whatever custodial provision was made." *Id.* at 19. STATE OF NEW YORK, REPORT OF THE STATE COMMISSION TO INVESTIGATE PROVISION FOR THE MENTALLY DEFICIENT 19 (1915).

The major problem, according to state officials, was that thousands of "mental defectives are at liberty in the community today . . . without restraint or public control." *Id.* at 34. "To attempt reformation is a gross waste of time and of money. The average cost per inmate in a specially organized institution for defectives is half of the average cost in our reformatory institutions." *Id.* at 35. The solution was to expand the institutions and to bring more of the "defectives" under control.

Accordingly, the legislature enacted on May 14, 1919 "AN ACT in relation to mental defectives. . . ." 1919 N.Y. Laws 1683, ch. 633. The law defined "mental defective" to mean "any person afflicted with mental defectiveness from birth or from an early age to such an extent that he is incapable of managing himself and his affairs, who for his own welfare or the welfare of others or of the community requires supervision, control or care, and who is not insane or of unsound mind." *Id.* at 1684, art. 1, § 2(5).



The legislation established a procedure for certifying that one's mental defect was "of such a nature as to require his *supervision, control* and care for his own welfare and for the welfare of others *or for the welfare of the community.*" *Id.* at 1697, art. 4, § 26. This determination was to be made by "qualified examiners." *Id.* § 25.

As a result of this law, state officials were soon overwhelmed with retarded people to segregate. The State Commission for Mental Defectives indicated in 1926 that although it was "gratifying to report progress during the year in additional housing for mental defectives[, t]he need of more beds is so great that it outweighs other considerations." STATE OF NEW YORK, EIGHTH ANNUAL REPORT OF THE STATE COMMISSION FOR MENTAL DEFECTIVES, JULY 1, 1925 TO JUNE 30, 1926, at 7 (Leg. Doc. No. 92, 1927). The scope of the physical expansion necessitated by the 1919 law was noted in the agency's Annual Report: "Defectives who are detrimental to society cannot *be segregated* until institution bed capacity is increased. Those of too low grade intelligence to be cared for in the public schools are often neglected at home and a source of economic disaster to the family. *The segregation of these in institutions* awaits erection of new buildings." *Id.* Thousands of beds were planned and provided throughout the state. *Id.*

**Pennsylvania.** In 1893 the Pennsylvania General Assembly authorized the construction of a large institution in western Pennsylvania with a capacity for at least "eight hundred inmates," to include a "custodial or asylum department." 1893 Pa. Laws 289, 290, No. 256, § 7. The facility was to be for the "reception" and "detention" of "idiotic and feeble-minded children," *id.* at 291, § 10, the sole restriction being that they be "under the age of twenty years," *id.* § 11. By 1903, a second institution similarly organized was authorized to be built in the eastern part of the state. 1903 Pa. Laws 446, No. 424.

In 1911, the Pennsylvania Conference of Charities and Corrections argued to the legislature that it had a

large problem on its hands. The legislature decided that a comprehensive study was necessary, and so adopted a joint resolution to establish a special commission, "the duty of which Commission shall be to take into consideration the number and status of feeble-minded and epileptic persons in the Commonwealth and the increase of such persons, and to report to the General Assembly at its next session a plan or plans *for the segregation, care, and treatment* of such defectives. . . ." 1911 Pa. Laws 927, § 1. The resolution was enacted because the legislature felt that "[a] proper regard for the public welfare requires that some action be taken looking to *the segregation* of such feeble-minded and epileptic persons." *Id.* (preamble).

On April 21, 1913, the Commission reported to the legislature that "[w]here the mental disability is of a degree which renders the afflicted individuals *unfit for citizenship*, or a menace to the peace, they are regarded and treated as *anti-social beings, and may be permanently segregated* in institutions especially constructed for their reception and care. The condition of mind in amentia is irremediable[;] *the segregation as the rule should therefore be permanent.*" REPORT OF THE COMMISSION ON THE SEGREGATION, CARE AND TREATMENT OF FEEBLE-MINDED AND EPILEPTIC PERSONS IN THE COMMONWEALTH OF PENNSYLVANIA 43 (1913).

The Commission considered retarded people "such an unpleasant burden, that parents usually are more than willing to part with them," *id.* at 38, but "[l]egislation" was "needed to *compel the segregation* of feeble-minded and epileptic persons," *id.* at 40. Who was to be incarcerated? "[A] type of mind must be established as a normal standard for the age, *race* and social status of each individual, and he who falls below this to a recognizable degree is *ipso facto* feeble-minded." *Id.* at 42.

Six weeks later, the legislature enacted comprehensive legislation, creating a new official purpose for the state's institution: "*segregation*" of all "idiotic, imbecile

or feeble-minded persons," 1913 Pa. Laws 494, No. 328, § 1, and the removal of all age restrictions on admissions, *id.* at 496, § 3. The lawmakers also established a new "Village for Feeble-Minded Women" to be "entirely and specially devoted to the reception, segregation [and] detention" of "feeble-minded women of child-bearing age. . . ." 1913 Pa. Laws 1319, No. 817. By 1922, the Superintendent of the Eastern Pennsylvania State Institution for the Feeble-Minded was reporting that "the general public [is] now convinced more than ever that it is a good thing to segregate the idiot and the imbecile." R. SMILOVITZ, A BRIEF HISTORY OF PENNHURST 1908-1926, COMPILED FROM SUPERINTENDENT'S DOCUMENTS (1974).

**Rhode Island.** The General Assembly of Rhode Island enacted in 1907 "AN ACT FOR THE ESTABLISHMENT, MAINTENANCE, MANAGEMENT, AND CONTROL OF THE RHODE ISLAND SCHOOL FOR THE FEEBLE-MINDED." 1907 R.I. Pub. Laws 89, ch. 1470. Within the institution there was created a special "custodial department for the care and custody of feeble-minded persons beyond school age, or who are not capable of being benefited by school instruction." *Id.* at 90, § 3. Institutionalization could be sought by filing a "complaint in writing" alleging that "any person within the district wherein such court is established is feeble-minded, so as to require restraint for his own welfare or for the welfare of the public." *Id.* at 91, § 6.

The purpose of the institution, according to the first annual report to the legislature, was to "not only protect the [feeble-minded] children themselves, but at the same time to guard society against the children." REPORT OF THE RHODE ISLAND SCHOOL FOR THE FEEBLE-MINDED IN EXETER 20 (1910). State officials strongly encouraged parents to commit their children voluntarily to the facility: "Society is made up of families and when the family suffers society suffers. Talk with any one who has had the opportunity to know intimately the history of families

in which there have been feeble-minded children, and let him tell of the cases of fathers driven to drink, whole families plunged into poverty and pauperism, and of mothers made insane or even done to death by the presence of the unfortunate child in the home." *Id.* at 21.

**Vermont.** In 1913, the General Assembly of Vermont created the "Vermont State School for Feeble-minded Children." 1913 Vt. Acts 96, No. 81, § 1. Proceedings to place a retarded person in the institution could be initiated by, in addition to a parent or guardian, any "selectman of the town . . . in which such child resides." *Id.* at 98, § 13.

In 1916, state officials "report[ed] that the people in Vermont are beginning to take a marked interest in the study of feeble-mindedness, and its baneful and increasing effects on the population of the State, and that with a better understanding of the conditions which exist, there will be a tendency to view the handling of the question in a more practical and common sense manner. The burden of feeble-mindedness is felt by the entire public, and every intelligent person who has carefully considered the subject realizes that *this blight on mankind* is increasing at a rapid rate, and that unless radical measures are adopted to curb the influences which tend to promote its growth it will only be a matter of time before the resulting pauperism and criminality will be a burden too heavy for any country or people to bear. *The feeble-minded are a parasitic, predatory class*, never capable of self-support or of managing their own affairs, and the majority of them ultimately become public charges." REPORT OF THE VERMONT STATE SCHOOL FOR THE FEEBLE-MINDED CHILDREN FOR THE PERIOD ENDING SEPTEMBER 30, 1916, at 17-18 (1916).

As a result of the actions of the state, "[t]he public is now fully aware of *the danger the defective is at large* and realizes the importance of instituting means for their control. There is nothing that can be done more effectively toward the prevention of feeble-mindedness, crime and



poverty and toward the promotion of our best citizenship, than to segregate the feeble-minded and properly care for them." *Id.* at 18.

### Midwestern States

**Illinois.** On June 24, 1915, the Illinois General Assembly passed a bill establishing a facility as an institution for the "detention of feeble-minded persons." 1915 Ill. Laws 245. Such "detention" was mandated not only for the retarded person's "own welfare," but also "for the welfare of others, or for the welfare of the community," so long as the person was "not classifiable as an 'insane person.'" *Id.* at 245-46, §1. "[A]ny reputable citizen of the county in which such supposed feeble-minded person resides or is found could seek the institutionalization of such a person by filing a petition stating that it was detrimental *"to the welfare of the community, for him to be at large."* *Id.* at 246, §3. The "guiding and controlling thought of the court" at these proceedings was to be not only "the welfare of the feeble-minded person" but also "the welfare of the community." *Id.* at 249, § 9.

**Indiana.** In 1914, Indiana officials reported to the Governor that there were still "at the most conservative estimate that can be made, at least four thousand feeble-minded in Indiana" requiring institutionalization, and that "[these] people are at large, a nuisance to the community in which they live; nearly all of them paupers; many of them petty criminals; the women filling the houses of prostitution; all of them poor, improvident, lazy — in short, incompetents. These people are increasing rapidly, and unless cared for will, in the next hundred years, bring an unbearable burden on our grandchildren and great-grandchildren. Shall we leave them such an inheritance, or shall we do something now to stop it? Were we to put all these four thousand defectives now at large into institutional care today, this institution could provide for practically all needing the care of an institu-

tion at the end of the next fifty years. No provision is made for adult male feeble-minded in this State, and these men *should be segregated from the world* in some place where they could be made in a measure self-supporting." THIRTY-SIXTH ANNUAL REPORT OF THE INDIANA SCHOOL FOR FEEBLE-MINDED YOUTH FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1914, at 14 (1914).

In 1915, the Board of State Charities of Indiana adopted a resolution that read: "Whereas, The problem of the mental defective is one of our greatest social as well as financial burdens and is increasing in importance and weight every year, and Whereas, Mental defectiveness is believed to be one of the most important if not the most important cause of pauperism, degeneracy and crime," resolved that a committee be established to make recommendations concerning this problem. Governor Ralston acted favorably on this resolution and appointed a Committee on Mental Defectives.

The work of the Committee and its first report, on November 10, 1916, was used to convince the governor and the legislature that it was "imperative that the State must very soon take cognizance of the large number of dependent defectives at large in the State, a menace to society, increasing at a rapid rate, and take steps to *segregate them from the public*, and thus check their reproduction not alone as a matter of philanthropy, but as an economic measure." THIRTY-EIGHTH ANNUAL REPORT OF THE INDIANA SCHOOL FOR FEEBLE-MINDED YOUTH, FORT WAYNE, INDIANA, FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1916, at 14 (1917). The Indiana officials were also "pleased to note that 'The Committee on Mental Defectives' appointed by you to study the problem of Mental Defectiveness in Indiana, recently urgently recommended the enactment of such a law, and we wish to strongly endorse their recommendation and urge that this remedial legislation be had at the coming session of the Legislature. We have deeply felt the need of this law in several cases in recent years, where we found ourselves

utterly helpless to prevent the withdrawal of girls by parents or relatives while we knew that were *unfit to be out in the world*. . . .” *Id.* at 15. They also recommended “the establishment of a new and separate institution to house them from *the danger of contact with the public*.” *Id.*

The Committee on Mental Defectives was reappointed by newly elected Governor James P. Goodrich. The Committee’s second report was published March 6, 1919.

One week later, the General Assembly passed as “emergency” legislation “AN ACT to provide for the establishment and government of an Indiana farm colony for feeble-minded” which incorporated practically all of the recommendations of the Committee on Mental Defectives. 1919 Ind. Acts 480, ch. 94. The lawmakers created a commission and ordered it to “select a suitable site for the farm colony” and to “purchase not less than 1,000 acres of land in a body” for it. *Id.* § 2. The law specified that “the buildings to be constructed for its use shall be plain and inexpensive in character,” *id.* at 482, § 6, and required that “the labor in constructing such buildings, improvements and facilities shall be supplied as far as applicable by the persons committed to the institution,” *id.*

The Committee on Mental Defectives, while expressing gratitude for this legislation, “recommend[ed] increased provision at the Farm Colony for Feeble-Minded” in order for the state “to provide adequately for such cases as cannot, without *menace to the community*, be provided for in the home or the public school.” MENTAL DEFECTIVES IN INDIANA: THIRD REPORT OF THE INDIANA COMMITTEE ON MENTAL DEFECTIVES 8 (1922).

The exact nature of the menace was described by the Governor’s Committee as follows: “The uncared-for insane, epileptic and feeble-minded constitute a social menace, but the *part played by the feeble-minded in discounting social progress is by far the most potent influence for evil under which society is struggling today*. . . .

Modern theory grants that the rights of the individual must not interfere with the welfare of the community. From the latter standpoint, the mental defective must be considered as a possible financial burden to the community, a potential menace through the commission of crime, and an increasing detriment to the race through the propagation of his kind. . . . What subject is more vital than this to the people of our state? The menace of the mental defective is a real and pressing one. All individuals and organizations interested in human welfare are urged to cooperate in a state-wide program for *informing the citizens of our state concerning the dangers that threaten*, and awakening them to the disastrous consequences if this important matter is neglected. This should result in such united action as will lessen the burden of pauperism, degeneracy, disease and crime, and decrease the cost to the taxpayers.” *Id.* at 6.

In addition to appropriating the increased funds requested for segregation, the legislature, on March 3, 1931, passed “AN ACT providing for the sexual sterilization of feeble minded persons.” 1931 Ind. Acts 116, ch. 50. Indiana has been the first state in the country to enact a sterilization law. 1907 Ind. Acts 877, ch. 215. The new law provided that, *at the point at which commitment of any mentally retarded person was sought*, “it shall be the duty of each of the examining physicians appointed by the court” to “certify to the court whether, in his opinion, such person is the probable potential parent of mentally incompetent *or socially inadequate* offspring likewise afflicted.” *Id.* § 1. Upon a finding by the court that “the welfare of society and of such feeble-minded person will be promoted by his or her sterilization,” the superintendent “may have performed upon such feeble-minded person” sterilization surgery “at such time as he may deem expedient.” *Id.* § 3.

**Iowa.** On March 17, 1876, the General Assembly of Iowa enacted legislation “FOR THE ESTABLISHMENT OF AN ASYLUM FOR FEEBLE MINDED CHIL-



DREN." 1876 Iowa Acts 145, ch. 152. Admission was originally limited to "children between the ages of seven and eighteen." *Id.* at 148, § 15. After the turn of the century, the state authorized the segregation of increased numbers of retarded people. The first to be confined, by enactment of April 7, 1902, were "all feeble-minded women under forty-six years of age." 1902 Iowa Acts 73, ch. 118. The next were "all feeble minded men under 46 years of age." 1909 Iowa Acts 171, ch. 173. In 1921, all age restrictions were repealed. 1921 Iowa Acts 126, ch. 129. State officials continually campaigned for the expansion of facilities for segregation, see, e.g., TWENTY-FOURTH BIENNIAL REPORT OF THE SUPERINTENDENT OF THE IOWA INSTITUTION FOR THE FEEBLEMINDED 7-8 (1922).

On April 13, 1929, the General Assembly enacted legislation "to create a state board of eugenics, to define the powers and duties of said board, [and] to fix the procedure in the sexual sterilization of persons." 1929 Iowa Acts 106, ch. 66. The members of the Board of Eugenics, which consisted of not only the superintendents of state institutions, but also the commissioner of public health, were ordered to "report to the state board of eugenics the names of all persons, male or female, living in this state, of whom he or she may have knowledge, who are feeble-minded . . . and who are a menace to society." *Id.* § 2.

**Kansas.** In 1881, the Legislature of Kansas established "the Kansas state asylum for idiotic and imbecile youth." 1881 Kan. Sess. Laws 74, ch. 35. Admission was limited to those "not over fifteen years of age." *Id.* at 75, § 6.

The superintendent of the institution, I.W. Clark, in 1906 urged the adoption of a law to enlarge the institution and to accomplish the segregation of feeble-minded persons of all ages. THIRTEENTH BIENNIAL REPORT OF THE KANSAS SCHOOL FOR FEEBLE-MINDED YOUTH. WINFIELD, KANSAS, FOR THE TWO YEARS ENDING JUNE 30, 1906, at 6 (1906). According to Superintendent Clark:

"Legislative attention to a more extended provision for the idiotic and feeble-minded is an imperative demand upon the state. For a score of years the opinions of philanthropists and of those interested in sociologic work have been steadily advancing in a certain direction, until now they are unanimously convinced that *as a matter of public policy all the feeble-minded class should be segregated and provided for by the state.* Various are the reasons which have led up to this conviction, and to most persons they are easily obvious. In this state to-day there are in the county-houses, and *in the communities at large, a large number of this class who are a menace, a blight and a misfortune both to themselves and to the public.*" *Id.* at 12. Therefore, the superintendent recommended that "[t]he age limit of fifteen years should be removed, and the capacity of the home be enlarged so as to receive *all persons who are feeble-minded, regardless of age.*" *Id.* at 6.

On March 12, 1909, the legislature acted. The name of the institution was "hereby changed to the State Home for Feeble-minded," and "[a]ll inmates admitted to said institution" were placed "under the custody and control of the superintendent of said institution, and the superintendent may restrain any such inmate when he deems it necessary for the welfare of such inmate and the proper conduct of the institution." 1909 Kan. Sess. Laws 560-61, ch. 233, §§ 1, 2.

In 1917, the legislature enacted a law providing that, if the Superintendent of the State Home for Feeble-minded "shall certify in writing" to the institution's governing board "that he or she believes that the mental or physical condition of any inmate would be improved thereby or that procreation by such inmate would be likely to result in defective or feeble-minded children with criminal tendencies, and that the condition of such inmate is not likely to improve so as to make procreation by such person *desirable or beneficial to the state*, [then] it shall be lawful to perform a surgical operation for the sterili-

zation of such inmate." 1917 Kan. Sess. Laws 443, ch. 299, § 1.

State officials applauded this legislation, and predicted a marked decrease in the number of feeble-minded persons. However, they reported that "the decrease will be nothing like so great as it should be *unless our immigration laws are so changed as to greatly reduce the number of undesirables from Europe entering this country*. . . . We shall be disappointed further that the decrease is no greater on account of the ease with which feeble-minded persons may obtain a marriage certificate, enter the marriage state and rear a family like unto themselves. . . . Asexualization will be condemned by some as being too harsh a measure, but it becomes incumbent on those who would discourage it to offer something better, for the future will compel us to act. If society by her philanthropic efforts annuls the law of the survival of the fittest, then self-interest will compel her to adopt measures which will prevent the multiplication of those who at best can only add degeneracy to the race." TWENTIETH BIENNIAL REPORT OF THE STATE TRAINING SCHOOL FOR THE TWO YEARS ENDING JUNE 30, 1920, at 7-8 (1920).

Two years later, the superintendent reported "that the population of the institution has grown steadily," and noted "the increased activity of welfare and Red Cross associations over the state that are *constantly on the lookout* for unfortunate people, both young and old" to be institutionalized. TWENTY-FIRST BIENNIAL REPORT OF THE STATE TRAINING SCHOOL FOR THE TWO YEARS ENDING JUNE 30, 1922, at 3 (1922). As a result of the state's policies, people were persuaded to place their retarded relatives in the institution. The Superintendent noted that "as a consequence our ward buildings are becoming crowded, some wards housing twenty per cent more than the estimated capacity. Additional ward room is a necessity." *Id.* at 11.

**Kentucky.** The General Assembly of the Commonwealth of Kentucky first chartered the "Kentucky Institution for Feeble-minded Children" as a corporate entity in 1894, although the facility apparently had been in existence previous to that date. *See* 1894 Ky. Acts 96, ch. 48, art. I, § 1. Admission to the institution at that time was limited to persons aged six through eighteen "whose mental condition is such that, in the judgment of the superintendent, they may be taught to read and write, or can be educated or trained to do work." *Id.* at 115, art. III, § 5.

In 1918, the General Assembly enacted more malevolent legislation, entitled "AN ACT to provide for the commitment, care, treatment, training, *segregation* and custody" of "feeble-minded" persons. 1918 Ky. Acts 156, ch. 54. The law defined "feeble-minded person" as one who "requires supervision, care, training, control or custody for his own welfare or for the welfare of others *or the community*." *Id.* § 1. It also established and authorized "The Farm Colony for the Feeble-Minded," including an ambitious plan for new construction on a 500-acre site. *Id.* at 156-57, 159-60, §§ 1, 9, 10. Proceedings to confine a person in the institution could be instituted against any person in the county who appears to be . . . feeble-minded." *Id.* at 161, § 16. The same law made it "one of the special duties of every *health officer and of every public health nurse* to institute proceedings to secure the proper segregation and custody of feeble-minded persons, likely to become fathers or mothers of other feeble-minded persons," *id.*, at 171, § 30, and made it a crime "to aid or abet the marriage of any feeble-minded person, and any person found guilty of aiding or abetting such marriage shall be fined not less than fifty dollars, nor more than five hundred dollars," *id.* § 32.

**Michigan.** In 1893, the Michigan Legislature established the "Home for the Feeble-Minded and Epileptic." 1893 Mich. Pub. Acts 412, No. 209. The institution was available to "[a]ll feeble-minded and epileptic persons be-



tween the ages of six and twenty-one." *Id.* at 416, §§ 20, 21.

In 1905, to insure long-term segregation, the legislature required that parents and guardians admitting their children to the home "*waive all right to remove* such inmate thereafter either permanently or for a limited time." 1905 Mich. Pub. Acts 169-70, No. 121.

A more comprehensive revision of the law took place four years later, 1909 Mich. Pub. Acts 189, No. 101, eliminating age restrictions, *id.* at 192, § 13, providing for roving physicians "empowered to go where such feeble-minded and epileptic person may be and make such personal examination of him as to enable them to offer an opinion as to his mental condition" in order to certify them as "feeble-minded," *id.* § 14.

If, following a hearing, "such person shall be found and adjudged to be feeble-minded or epileptic the court shall immediately issue an order for his admission to the home for the feeble-minded." *Id.* at 194.

State officials described the value of the new law in maintaining life-long segregation and control in their report to Governor Woodbridge Ferris: "Prior to the enactment of the law of 1909, patients were admitted to this institution by direct application either by parents, guardians, or certain public officials. The matter of the status of these patients was constantly before the Board of Control. The Board found it impossible to *hold certain cases where, in their opinion, the welfare of the State would dictate their being held.* We therefore went to the Legislature, requesting the passage of an act bringing all these cases, where the patient had not had his day in court, before the Probate Courts of the several counties for review and legal commitment. We now have no patients not committed by the Probate Court." TENTH BIENNIAL REPORT OF THE BOARD OF CONTROL OF THE MICHIGAN HOME AND TRAINING SCHOOL AT LAPEER FOR THE BIENNIAL PERIOD ENDING JUNE 30, 1914 (1914).

As John N. McCormick, Chairman of the State Board of Corrections and Charities later stated in official, published instructions to Dr. H. A. Haynes, Superintendent of the Michigan home: "The members of this Board consider it imperative that ample provision be made for the *segregation* and proper care of feeble-minded persons. A recent survey of Michigan removes any doubt as to *the plain duty of the State regarding feeble-mindedness*, not only from a sociological but an economical standpoint as well. From our discussion of the situation with you at the meeting of this Board held at your institution, we are of the opinion that the items stated in your estimate of appropriations for the next two years are needed, and the same are hereby approved." ELEVENTH BIENNIAL REPORT OF THE BOARD OF CONTROL OF THE MICHIGAN HOME AND TRAINING SCHOOL AT LAPEER FOR THE BIENNIAL PERIOD ENDING JUNE 30, 1916, at 7 (1916).

On May 25, 1923, the Michigan legislature adopted "AN ACT to authorize the sterilization of mentally defective persons," which class was "deemed to include idiots, imbeciles and the feeble-minded, but not insane persons." 1923 Mich. Pub. Acts 453, No. 285, § 1. "Whenever a person is adjudged defective," the court was authorized to "order such treatment by x-rays or operation of vasectomy or salpingectomy. . . ." *Id.* at 454, § 2.

In a 1929 amendment, the legislature "hereby declared [it] to be the policy of the state to prevent the procreation and increase in number of feeble-minded, insane and epileptic persons, idiots, imbeciles, moral degenerates, and sexual perverts, *likely to become a menace to society* or wards of the state. *The provisions of this act are to be liberally construed to accomplish this purpose.*" 1929 Mich. Pub. Acts 689-90, No. 281, § 1. The law made it "the duty" of state officials operating the Home for Feeble-minded "to bring to the attention of the governing board or body of such institution and to the state welfare commission" any "mentally defective person who would be likely to procreate children unless

closely confined or rendered incapable of procreation" for whom they were "of the opinion" that it would be "for the best interest of such person *and of society* that such mentally defective person should be sexually sterilized." *Id.* at 690, § 4. The law made it "the duty," in turn, of "the governing board or body of such institution and the state welfare commission to cause an investigation, and examination to be made to determine whether such mentally defective person would be likely, *if allowed to mingle in society*, to procreate children having an inherited tendency to feeble-mindedness, insanity, idiocy, imbecility, epilepsy, or sexual degeneracy, and who *would be likely to become a social menace* or a ward of the state, and whether there is no probability that the condition of such person would improve to such an extent as to avoid such consequences." *Id.* at 690-91.

**Minnesota.** In 1909, the legislature of Minnesota enacted a law "providing a department for incurables" for "all idiotic and epileptic persons resident of the state. . . ." 1909 Minn. Laws 72, ch. 80. A decade later, because the institution, located at Faribault, had filled beyond capacity, the legislature authorized the state board of control "to select from the public lands of this state, the title to which is vested in the state, not to exceed two (2) sections of land to be used as a location for a colony for feeble-minded persons. . . ." 1919 Minn. Laws 475, ch. 407, § 1. In 1925, the legislature authorized residents of its institutions "to be sterilized by the operation of vasectomy or tubectomy." 1925 Minn. Laws 140, ch. 154.

**Missouri.** In 1899, the "Missouri Colony for the Feeble-minded" was established. 1899 Mo. Laws 1821, ch. 118, art. 10. As the institution's population grew, the "board of managers of said colony" was "empowered to establish other colonies in temporary or permanent camps." 1919 Mo. Laws 183-84, § 2.

State officials continually requested increased appropriations for expansion. In one annual report to the legislature, for example, Dr. E. E. Brunner, superintendent

of the institution, stated: "We need another building to care for the custodial type of idiot patients as that building is entirely overcrowded." SIXTH BIENNIAL REPORT OF THE BOARD OF MANAGERS OF THE STATE ELEMOSYNARY INSTITUTIONS TO THE FIFTY-SEVENTH GENERAL ASSEMBLY OF THE STATE OF MISSOURI FOR THE TWO FISCAL YEARS BEGINNING JANUARY 1, 1931, AND ENDING DECEMBER 31, 1932, at 291 (1933). According to Superintendent Brunner, "[t]he number of applications is not an indication that the number of feeble-minded is on the increase in the State, but to the education of the people of the State as to the significance of feeble-mindedness and the need of permanent custodial care. . . ." *Id.* at 288.

**Nebraska.** On March 5, 1885, the Legislature of Nebraska passed "AN ACT to establish and endow an Asylum Home for feeble-minded children and adults at or near the city of Beatrice, Nebraska, and making appropriation and levy therefor." 1885 Neb. Laws 255, ch. 52.

By 1914, Silas A. Holcomb, chairman of the newly established state Board of Commissioners, was writing in his first report to the governor and legislature that "[t]he population of the institution has increased to the point where its capacity is taxed to the limit. The demand for additional admissions is steady and will continue." The Board recommended an ambitious expansion program, "[w]ith a view of relieving the congested condition and making suitable provisions for future admissions. FIRST BIENNIAL REPORT OF THE BOARD OF COMMISSIONERS OF STATE INSTITUTIONS TO THE GOVERNOR AND LEGISLATURE OF THE STATE OF NEBRASKA FOR THE BIENNIUM ENDING NOVEMBER 30, 1914, at 9 (1915).

Expanded institutions would be necessary partially as a result of projected population increases for the state. *See id.* They would also be the necessary result, however, of a comprehensive program "submit[ted] for the serious consideration of the Governor and the legislature" of testing and registration which "would unquestionably re-



veal others who are feeble-minded and who *ought not to be returned to society.*" *Id.* at 10.

Observing that "[t]he *only effective measures* to meet these conditions are *segregation and sterilization,*" the Board criticized the then current law: "but in our state neither of these may be applied except as a voluntary proceeding on the part of the legal guardian of the feeble-minded person. . . . It is not a proceeding by which a feeble-minded person may be committed to nor detained in the institution *against the desire* of the parent or guardian." *Id.* at 11. By amending the law, "*the community is enabled to seclude those who cannot safely be allowed to mingle freely with their fellows.* We, therefore, recommend that a statute, similar to those above mentioned, be enacted by this state to provide that admission to the institution for feeble-minded be by order of commitment entered by the county court of the proper county, after due hearing and finding upon a petition filed by the husband, wife, parent, guardian or other person standing in loco parentis to the alleged feeble-minded person, *or* by the superintendents, managers or trustees of any institution having such person in charge, or by the county commissioners, county attorney, superintendent or principal of schools, or a probation officer of the county in which such alleged feeble-minded person shall reside." *Id.* at 11-12.

The legislature responded, enacting an amendment on April 14, 1915, extending the list of people eligible to initiate commitment proceedings to include "the county commissioners, county attorney, any poor law official, any superintendent or principal of schools, or any probation or parole officer of the county of which such idiotic, imbecile or feeble-minded person is a bona fide resident, . . . and the superintendent or managing officer of any public or charitable institution having in charge any idiotic, imbecile or feeble-minded person." 1915 Neb. Laws 294, ch. 131. "[D]etention" was mandated if "it shall appear that the person named in the application is an idiot,

an imbecile or a feeble-minded person and that the best interests of such person *or the welfare of society* require that he be committed to said institution for the feeble-minded." *Id.* at 295. "It shall be the duty of said institution to receive all such idiotic, imbecile and feeble-minded persons duly committed thereto and to detain them therein, and to arrest and return any who may escape therefrom." *Id.*

Shortly thereafter, the lawmakers passed "AN ACT to authorize the sterilization of feeble-minded," whose "children would probably become a social menace" and "would be harmful to society." 1915 Neb. Laws 554-55, ch. 237. The act was not approved by the governor, but became operative without his signature.

In 1921, the legislature changed the name of the institution from the "Nebraska Institution for Feeble-minded Youth" to simply the "Nebraska Institution for the Feeble-minded," in recognition of the abandonment of all age restrictions. 1921 Neb. Laws 843, ch. 241, § 1. "The objects of the institution shall be to provide *custodial care* and humane treatment for those who are feeble-minded, *to segregate them from society,* to study to improve their condition, [and] *to classify them.*" *Id.*

**North Dakota.** The Legislative Assembly of North Dakota in 1903 adopted "AN ACT to Establish an Institution for the Feeble Minded," to be "permanently maintained at or near the city of Grafton" for "*all* idiotic and epileptic persons residents of this state." 1903 N.D. Sess. Laws 142, 143, ch. 108, §§ 1, 6. State Superintendent L. B. Baldwin reported that it was "advisable that they be placed in institutions of this character *for life.* A relationship exists between the forms of degeneracy, namely, the criminal, the inebriate, the prostitute and the feeble minded." The view of state officials was that "to protect posterity," it was necessary to undertake "the gathering of this great number of defectives into institutions and colonies." FIRST BIENNIAL REPORT OF THE NORTH DA-

KOTA INSTITUTIONS FOR FEEBLE MINDED AT GRAFTON FOR THE PERIOD ENDING JUNE 30, 1904 TO THE GOVERNOR OF NORTH DAKOTA 9-10 (1904).

In 1909, the Legislative Assembly promoted the permanent segregation of those committed by providing that "any inmate of such institution shall not be removed therefrom," except by written application, and "said request must receive the approval of the superintendent before such inmate can be removed." 1909 N.D. Sess. Laws 317-18, ch. 213, § 1.

In 1913, the legislature provided that "any feeble minded person who is *offensive to the public peace or to good morals, and who is a proper subject for classification and discipline in the institution*, may be committed" without consent. 1913 N.D. Sess. Laws 222, ch. 166, § 1. This provision was enacted as an emergency measure in view of "the fact that there is now no law for compulsory commitment of feeble-minded persons *obnoxious to the peace and good morals of the public*." *Id.* § 3.

The Legislative Assembly authorized the superintendent to "admit to the institution temporarily, without commitment, under such rules and regulations as the Board of Administration may prescribe, for purposes of observation, such children or adults as are *suspected of being feeble minded or idiotic*, to ascertain whether or not such person is actually mentally defective and a proper case for care, treatment and training in an institution for the feeble-minded." 1921 N.D. Sess. Laws 123, ch. 64.

It was also made "the duty of the superintendent" to "report quarterly to the Board of Examiners herein provided for, all feeble-minded" who were considered as having "potential to producing off-spring, who, because of inheritance of inferior or antisocial traits, *would probably become a social menace*. . . ." 1927 N.D. Sess. Laws 433, ch. 263, § 1. The Board would, following a hearing, "make an order requiring such person to be sterilized." *Id.* at 434, § 3. The purpose of the law was to "*protect society from the menace of procreation by said inmate*." *Id.* § 5.

**Ohio.** As early as 1857, the General Assembly of Ohio established the "Ohio State Asylum for Idiots." 1857 Ohio Laws 190, 191.

In 1898, Ohio lawmakers established "a custodial department" for the "detention" of "idiotic and feeble-minded children *and adults*," 1898 Ohio Laws 209, § 1, and established an involuntary commitment procedure, *id.* at 211, § 6.

In 1912, Superintendent E. J. Emerick called for increased facilities. "If we could *segregate* these defectives when they are young and *keep them confined during their natural lives*, it would obviate the expense of having them committed repeatedly to our penitentiaries when they grow older. Under our present plan they are sent to our penal institutions for a short term after committing some crime, allowed to go out again, scatter their progeny, and commit other crimes and depredations, only to be re-committed time after time. . . . If we take these children into our institution, brighten them up as best we can, and turn them loose on the public, it has not only been a waste of time, money, and energy, but we have done the world an irreparable injury." Emerick, *The Segregation of the Defective* in PROCEEDINGS OF THE NATIONAL EDUCATION ASSOCIATION, 1912, at 1291-92 (1912). Emerick and others continued the same theme for the next several years. See E. J. EMERICK, THE PROBLEM OF THE FEEBLEMINDED (1913); JUVENILE PROTECTIVE ASSOCIATION OF CINCINNATI, THE FEEBLEMINDED, OR, THE HUB TO OUR WHEEL OF VICE (1915); M. SESSIONS, THE FEEBLEMINDED IN OHIO (1918).

In 1919, the legislature established "an additional institution in the state for the *custody, supervision, control, care, maintenance*, and training of feeble-minded persons," to receive "feeble-minded persons committed to its custody and care *from any county in the state*." 1919 Ohio Laws 430, § 1.

**South Dakota.** South Dakota's first facility for the segregation of retarded people was a department of the



Northern Hospital for the Insane established as early as 1893. 1893 S.D. Sess. Laws 169, ch. 101. In 1917, the legislature enacted the state's first sterilization law, making it "the *duty*" of the State Board of Charities and Corrections to order the sterilization of "*any* of said inmates [who] would produce children with a *tendency* to disease, feeble-mindedness, idiocy or imbecility. . . ." 1917 S.D. Sess. Laws 378-379, ch. 236, § 2.

In 1921, the legislature passed an act "RELATING TO THE SEGREGATION OF FEEBLE MINDED." 1921 S.D. Sess. Laws 344, ch. 235. The law created the State Commission for the Control of the Feeble Minded and empowered it "to make all necessary rules and regulations pertaining to the *segregation, care and control* of feeble minded persons. . . ." *Id.* §§ 1, 3. It was "the purpose of this act to provide that *all feeble minded persons resident within this state shall become the wards of the state and shall be kept segregated.*" *Id.* § 2. In order to enforce this mandate, the "state commission shall make a survey of all state institutions *and of the state generally* to ascertain the persons whom they believe to be feeble-minded in order that said state commission may make necessary complaints to the county commission." *Id.* at 344-45, § 5. Additionally, "[a]ll teachers" were required to "report *all feeble-minded children coming to their attention* to the state board." *Id.* at 345. This system of outreach efforts to systematically segregate retarded people became known nationwide as the "South Dakota Plan," and became a model for similar efforts in other states. The legislation was deemed by the Commission to "constitute a substantially laid foundation upon which to erect the super-structure of a wise social and economic administration of the feeble-minded problem." STATE OF SOUTH DAKOTA, SECOND BIENNIAL REPORT OF THE COMMISSION FOR SEGREGATION AND CONTROL OF THE FEEBLE-MINDED FOR THE PERIOD ENDING JUNE 30, 1928 TO THE GOVERNOR 2 (1928).

The Commission proposed legislation to require the "identification of all feeble-minded in the state and their registration as a matter of record [,] . . . a continuative census [,] . . . supervision and control by properly constituted authorities [,] . . . [and] the operation of the sterilization law and the anti-marriage law. In fact the law is designed to give *the defective* the protection of the state, and at the same time to *protect the state against his social inadequacy.*" STATE OF SOUTH DAKOTA, THIRD BIENNIAL REPORT OF THE COMMISSION FOR SEGREGATION AND CONTROL OF THE FEEBLE-MINDED FOR THE PERIOD ENDING JUNE 30, 1930 TO THE GOVERNOR 3 (1930). The Commission warned that the proposed legislation was necessary due to the large numbers of "feeble-minded" who were "at large and uncontrolled by the state." *Id.* at 4.

On February 19, 1931, the comprehensive law requested by the Commission was enacted. The term "feeble minded" was broadly and vaguely defined to include "*all individuals, except the insane, who by reason of mental deficiency are incapable of doing the work of the grades in the public schools in a reasonable ratio to their years of life; or who by reason of mental deficiency and other associated defects are incapable of making the proper adjustments to life* for one of their chronological age." 1931 S.D. Sess. Laws 200, ch. 153, § 1. The Commission drafted into the law its paramount "authority in all matters pertaining to the care, supervision, and control of all feeble-minded persons in the State of South Dakota not confined within the state school and home for the feeble minded. Said commission shall determine the conditions under which such feeble minded persons shall be permitted to remain outside of said institution; and when, and under what conditions, commitment to such institution shall be required." *Id.* § 2. The Commission was given "the duty" to "maintain a continuative census of the feeble minded in the state, and all boards of education, school principals, county superintendents of

schools, city school superintendents, and teachers, are hereby specifically required to give said commission, or its agents, *such access as the commission, or its agents, deem necessary* to all school records, and to all children within their control for purposes of examination. . . ." *Id.* § 3(a). Moreover, it was to "be the duty of all teachers, city school superintendents and county superintendents of schools" as well as "the duty of all doctors, nurses, hospitals, penal and charitable institutions, county welfare boards, public health officers, and public officers, boards, or commissions within the State of South Dakota, to report to the state commission for the control of the feeble minded the name, age, and residence of all children believed by them to be feeble minded, and also to furnish whenever requested by the state commission for control of the feeble minded any and all information which they may have relative to the name, age, residence and antecedents of any person believed to be feeble minded." *Id.* § 3(b), (c). "Sub-Commissions," were established in each county of the state "under the direct authority of the state commission" with the "specific authority" to "apprehend, examine, commit, establish guardianships, transport, and maintain the custody of any feeble minded person within their respective counties." *Id.* at 200-01, § 4. "It shall also be the duty of each sub-commission to declare to be feeble minded all of those persons whom the sub-commission, or whom a majority of the members of such sub-commission, find upon investigation and examination to be feeble minded; and forthwith to commit such feeble minded to the supervision and control of the state commission. . . ." *Id.* at 201, § 6.

This legislation, according to the Commission, "would serve the purpose of *securing control and supervision of all the feeble-minded outside of institutions in the State.*" STATE OF SOUTH DAKOTA, FOURTH BIENNIAL REPORT OF THE COMMISSION FOR SEGREGATION AND CONTROL OF THE FEEBLE-MINDED FOR THE PE-

RIOD ENDING JUNE 30, 1932 TO THE GOVERNOR 3 (1932). "[T]he Commission was thoroughly convinced that the *great problem of feeble-mindedness* lay in that large group of feeble-minded *outside of institutions,*" who were "scattered throughout the population" and "*in possession of all the rights and liberties of normal people.*" *Id.* The Commission found that most of "the feeble-minded were at large and uncontrolled by the State," *id.*, but that would change: "To have control there must be: 1st, Identification; 2nd, Examination; 3rd, Registration; 4th, Supervision; 5th, Prevention (of marriage); 6th, Sterilization. The new law is designed to fulfill these requirements." *Id.*

Commission personnel "were sent into the various counties and through contact with the schools, welfare boards, health officers, social agencies, physicians, nurses, and public agencies of every kind, sought to *locate every possible feeble-minded individual.*" *Id.* at 9.

Two years later, the Commission reported "the number who have been committed to the State Commission, *those who are segregated in the institution and those who have been sterilized, are now all under State Control.*" STATE OF SOUTH DAKOTA, FIFTH BIENNIAL REPORT OF THE STATE COMMISSION FOR THE CONTROL OF THE FEEBLE-MINDED FOR THE PERIOD ENDING JUNE 30, 1934 TO THE GOVERNOR 5 (1934). The Commission complained, though, that the state's sterilization law was "much too complicated and cumbersome to achieve the best results." *Id.*

The legislature agreed, enacting legislation the following February giving each Sub-Commission, following a hearing, "the power to make an order for the sterilization of any feeble-minded person found within its respective county. . . ." 1935 S.D. Sess. Laws 163, ch. 113, § 1. A petition for sterilization could be "filed with the Chairman of the Sub-Commission of the County in which



the person believed to be feeble-minded is found," by "any resident of the County in which such person may be found." *Id.*

The "South Dakota Plan" was in effect in similar form at least through 1968. See STATE OF SOUTH DAKOTA, TWENTY-SECOND BIENNIAL REPORT OF THE STATE COMMISSION FOR THE MENTALLY RETARDED FOR THE PERIOD ENDING JUNE 30, 1968 TO THE GOVERNOR (1968).

**Wisconsin.** Public support in Wisconsin for segregation of retarded people did not begin in earnest until the 1890s. Among those lobbying for the establishment of an institution, through a state-wide petition drive, were the Board of Health, the Federation of Women's Organization, and the State Teachers Association. One such petition, signed by the leading citizens of Washburn County in 1891, called for the building of an institution "for the feeble-minded, who are a constant menace to the good order of society, and to social and domestic safety and tranquility. . . ." Quoted in A. RUGG, ONE HUNDRED YEARS OF PUBLIC CARE FOR PEOPLE WITH MENTAL RETARDATION IN WISCONSIN 8 (1983).

Dr. J. H. McBride, a member of the Wisconsin Conference of Charities and Corrections, stated the popular belief that retarded children should be removed from the family: "That an idiot child is, with its repulsive appearance and disorderly habits, a demoralizing association for brothers and sisters, a thing that would seem to go without saying. Daily experience with the course and rude behavior of an idiot is an experience that must, of necessity, be seriously injuring to young and tender natures." PROCEEDINGS OF THE WISCONSIN CONFERENCE OF CHARITIES AND CORRECTIONS 118 (1890).

In 1895, the legislature established "The Wisconsin Home for feeble-minded." 1895 Wis. Laws 280, ch. 138, § 1. The facility was for "[a]ll feeble-minded, epileptic and idiotic persons, residents of the state." *Id.* at 241, § 4. The law was amended in 1897, to provide that "when-

ever it shall appear that any feeble-minded female of child-bearing age is, by reason of her condition, a menace to society, it is the duty of the supervisor to bring the person before the county judge. . . ." 1897 Wis. Laws, ch. 360, § 1.

In his first biennial report, Superintendent Alfred W. Wilmarth requested of the legislature increased appropriations for additional dormitories in order to "purge society and obstruct the increase of feeble-mindedness." WISCONSIN BOARD OF CONTROL, BIENNIAL REPORT 321 (1898). What training that was provided focussed upon "educating the child as a useful member of the institutional community where he will always live." WISCONSIN BOARD OF CONTROL, BIENNIAL REPORT 356 (1904). Indeed, Superintendent Wilmarth complained in his report of the "annoyance . . . created by friends of some children who demand their release when they are entirely unfit to go into general society." *Id.* at 376.

By 1912, state officials were reporting that the work of the institution basically "consist[ed] of separating them from society, feeding, and clothing them." WISCONSIN BOARD OF CONTROL, BIENNIAL REPORT 20 (1912). That same year, "the Board of Control was directed not to consider 'paroling' anyone who 'might' become a menace to the community." *Id.*

A Visiting Committee of the legislature endorsed the continuation and extension of this approach and, in addition, urged the enactment of a sterilization law because of the "present danger to the race." Report of the Legislative Visiting Committee, SENATE JOURNAL 263 (48th Leg. Sess.). In 1913, the legislature authorized the sterilization of residents of the institution for whom it was found "that procreation is inadvisable." 1913 Wis. Laws 972, ch. 693, § 3. The same day, the lawmakers made room for the incarceration of more "feeble-minded" by establishing a second institution. *Id.* at 963, ch. 689, § 1. It was needed since the population of the Home for the Feeble-minded increased from 394 to 1060 in the period

1900-1920. WISCONSIN BOARD OF CONTROL. BIENNIAL REPORT 290 (1920).

### Southern States

**Alabama.** On September 29, 1919, the legislature of Alabama established "The Alabama Home" for "mental inferiors." 1919 Ala. Acts 738, No. 568, § 2.

"[D]eclared to be mental inferiors or deficient, or feeble-minded" by the legislature for purposes of confinement at the Home were "[a]ll persons of *whatever age, who are deficient or inferior* to the extent of being classed in either of the following groups of the feeble-minded: That is to say, idiots, imbeciles, feeble-minded or morons, and any of whom may be, or may not be epileptics, but not violent or insane."

*Id.* at 739, § 7. The terms "feeble-minded" and "mental inferior or deficient" were defined in the act to "include every person with such a degree of mental defectiveness from birth, or from an early age that he is unable to care for himself and to manage his affairs with ordinary prudence, *or that he is a menace to the happiness or safety of himself or of others in the community*, and requires care, supervision, and control either for his own protection *or for the protection of others.*" *Id.*

The courts were given "the power and authority to commit such person to the Home *notwithstanding* the family or relatives may object thereto." *Id.* at 740, § 9.

The same enactment also instructed the operators of the Alabama Home, that, if "they deem it advisable they are hereby authorized and empowered to sterilize any inmate." *Id.* § 13.

The law provided that "[t]he Superintendent must not grant a parole to any inmate unless he is of the opinion that it will not be detrimental to such inmate *or to society*, and the Superintendent must recall said parole whenever he is satisfied that the welfare of such paroled

inmate, *or of the community to which said inmate is paroled* requires it." *Id.* § 14.

**Arkansas.** Arkansas' institution "for the Feeble-Minded" was created by an act of the legislature on March 6, 1917. 1917 Ark. Acts 942.

The law broadly defined "feeble-minded" for the purposes of confinement at the institution "to include *all degrees of mental defect* due to arrested or imperfect mental development. Those feeble-minded persons possessing approximate mental development not to exceed that of a normal child of three, shall be classed as 'idiots;' those approximately of the mentality of children from four to seven, inclusive, shall be known as 'imbeciles;' and those approximately with the mental development of normal children from eight to twelve, inclusive, shall be known as 'morons.'" *Id.* § 11.

**Florida.** In 1919, the Florida Legislature, noting "an alarming state of facts" in a report submitted to it by a committee appointed by the governor (*see* 1915 Fla. Laws 263, ch. 6920), and further noting "[f]rom the findings of the said Committee there can be no doubt that there should be established and created in this State an Institution for the care of Epileptic and Feeble-Minded, where they can be segregated," established the "Florida Farm Colony for Epileptic and Feeble-Minded." 1919 Fla. Laws 231, ch. 7887, preamble & § 1.

The Colony was founded "to the end that these unfortunates may be prevented from reproducing their kind, *and the various communities and the State at Large relieved from the heavy economic and moral losses arising by reason of their existence.*" *Id.* § 8. Its purpose was "for the segregation" of the "feeble-minded." *Id.*

**Georgia.** On August 19, 1919, the General Assembly of Georgia passed "An Act to establish in the State of Georgia an institution to be known as the 'Georgia Training School for Mental Defectives.'" 1919 Ga. Laws 377, No. 373. The institution was ordered built "as soon as



possible" for all "defectives" who "constitute *menaces* to themselves or the community." *Id.* § 1.

The statute mandated that "preference in admission shall be given to children and women of child-bearing age," but the institution was open to *any* "defective" who "constitutes a *menace to the happiness* of himself or of others in the community" who were "not insane or of unsound mind." *Id.* at 379, § 3.

The institution opened in 1921. A year later, its first superintendent, George H. Preston, M.D., complained that the facility was "not large enough to fulfill the demands made of it." ANNUAL REPORT OF THE GEORGIA TRAINING SCHOOL FOR MENTAL DEFECTIVES, GRACEWOOD GEORGIA 4 (1922). According to the Report, "the fact of primary importance to remember is that a defective child will be a defective adult, and will die a defective. There is not a philosopher's stone to turn the base metals of defect into gold." *Id.*

The Georgia legislature enacted the state's first sterilization law, "for the protection of . . . future generations," in 1937. 1937 Ga. Laws 414, No. 5.

**Louisiana.** The "State Colony and Training School" was established by the Louisiana legislature in 1918 as "an institution especially provided for the feeble-minded persons of the state of Louisiana." 1918 La. Acts, No. 141, § 1. A "[f]eeble-minded" person was defined as "any person afflicted with mental defectiveness" who "requires supervision, control and care for his own welfare, or for the welfare of others, or for the welfare of the community, who is not classifiable as an insane person." *Id.* § 2. "When any person residing in this state shall be supposed to be feeble-minded," and "it is unsafe and dangerous to the welfare of the community for him to be at large without supervision, control, and care, any relative, guardian or conservator or any reputable citizen of the parish in which such supposed feeble-minded person resides" was authorized to seek that person's commitment to the state colony. *Id.* § 11. The law required "the guid-

ing and controlling thought of the court throughout the proceedings" to be not only "the welfare of the feeble-minded person" but also "the welfare of the community." *Id.* § 15.

**Mississippi.** On April 3, 1920, the Mississippi Legislature passed "AN ACT to provide for the establishment and maintenance of the Mississippi School and Colony for the Feeble-minded . . . [and] to prevent the multiplication of feeble-minded criminals and paupers." 1920 Miss. Laws 288, ch. 210. The law included in its definition of "feeble-minded" those who "constitute *menaces to the happiness* or safety of themselves or of other persons in the community, and require care, supervision and control either for their own protection or for the protection of others." *Id.* § 2. The enactment was based upon the legislative finding that "the greatest danger of the feeble-minded to the community lies in the frequency of the passing on of mental deficiency from one generation to another, and in the consequent propagation of criminals and paupers." *Id.* at 289. "[A] sufficient acreage of the Rankin County state convict farm" was ordered selected and improved "as soon as practicable" for the establishment of the Mississippi Colony, bearing in mind the desirability of a large tract of land to provide for the growing demands of said institution." *Id.* at 290, § 8. The "Plan of the Mississippi Colony" was to provide "the most economical production of shelter, with the necessary distribution of heat, light and food, at the same time securing the isolation and segregation required." *Id.* at 291, § 9.

The chancery courts were given jurisdiction over "all cases of legal inquiry in regard to feeble-mindedness, including idiocy, imbecility, and the higher grades and varieties of mental inferiority which render the subjects *unfit for citizenship*." *Id.* at 294, § 17. Application for commitment could be made "[a]t any time" by "any relative" to the clerk of the court, "but if the relatives of any feeble-minded person shall neglect or refuse to make appli-

cation to the clerk of the chancery court to have him adjudged feeble-minded, *and shall permit him to go at large*, the clerk of the chancery court shall, on the application, in writing and under oath, of a citizen of the county in question, issue a summons to the sheriff to summon the alleged feeble-minded person and his parent, guardian, or next friend to contest the application." *Id.* An order of commitment was to issue if the court "shall be satisfied that the person is feeble-minded, and that for the safety or happiness of the feeble-minded himself, *or for the safety or happiness of other persons in the community*, he should be committed to the Mississippi Colony." *Id.* at 297, §23.

The legislature later authorized "the operation of sterilization" to be performed "whenever" the Mississippi Colony's superintendent "shall be of the opinion that it is for the best interests of the patients *and of society* that any inmate of the institution under his care should be sexually sterilized," 1928 Miss. Laws, ch. 294, §1 (emphasis provided), and that the board of trustees of the Colony "shall find that the said inmate" is "feeble minded or epileptic, and by the laws of heredity is the probable potential parent of *socially inadequate offsprings* likewise afflicted, that the said inmate may be sexually sterilized without detriment to his or her general health, and that the welfare of the inmate *and of society* will be promoted by such sterilization." *Id.* at 372, §2.

**North Carolina.** The General Assembly of North Carolina in 1911 established the "North Carolina School for the Feeble-minded" for all persons "idiotic and feeble-minded six years of age and upward." 1911 N.C. Sess. Laws 256, ch. 87, §1. The clerk of the county court was authorized to order commitment "[w]henver it is made to appear" that "any person resident in said county" was "a fit subject" for institutionalization. *Id.* at 257, §4. By a 1915 amendment, the General Assembly authorized commitment proceedings for children to be brought by, in addition to a parent or guardian, "third, by a guardian

duly appointed; fourth, by the superintendent of any county home, or by the person having the management of any orphanage, association, charity, society, children's home workers, ministers, teachers, or physicians, or other institutions where children are cared for. Under items third and fourth, *consent of parents, if living, is not required.*" 1915 N.C. Sess. Laws 337-38, ch. 266, §3.

According to state officials, "the aim of the institution" was "to *segregate*" all of "the state's mental defectives." THIRD BIENNIAL REPORT OF THE CASTLE TRAINING SCHOOL, KINSTON, N.C., FOR THE YEARS 1915-1916, at 13 (1916). "[I]f for a period of two or three generations mentally defective men and women were prevented by segregation or sterilization from propagating their kind, mental deficiency would be very materially decreased. . . ." *Id.* at 14.

By 1923, the General Assembly had authorized the commitment of "feeble-minded and mentally defective persons of *any age* when in the judgment of the officer of public welfare and the board of directors of said institution it is deemed advisable." 1923 N.C. Sess. Laws 223, ch. 34, §2.

Under 1929 legislation, the superintendent of the institution was "hereby authorized and directed to have the necessary operation for asexualization or sterilization performed upon *any* mentally defective or feeble-minded inmate or patient thereof, as may be considered best in the interest of the mental, moral, or physical improvement of the patient or inmate, *or for the public good.*" 1929 N.C. Sess. Laws 28, ch. 34, §1.

**Oklahoma.** The Oklahoma legislature established the "Oklahoma Institution for the Feeble-minded" in 1909, for "*all* imbecile and idiotic persons of whatever state who are not insane." 1909 Okla. Sess. Laws 534-35, 536, ch. 34, art. 2, §§1, 4. Application for a commitment could be made by the father or mother, or: "Third: By a guardian duly appointed. Fourth: By the superintendent of any county alms house. Fifth: By the persons having



the management of any institution or asylum where children are cared for. Sixth: By the trustees of any township in Oklahoma. Under the items 'Three,' 'Four,' 'Five,' and 'Six' above, *the consent of parents is not required.*" *Id.* at 538, §8.

In 1931, the legislature authorized the superintendent of the institution to sterilize those "afflicted with" such conditions as "idiocy" or "imbecility." 1931 Okla. Sess. Laws 80, ch. 26, art 3.

**South Carolina.** On February 12, 1918, the General Assembly of South Carolina passed "AN ACT to Establish the State Training School for the Feeble-minded, and to Provide for Its Government and Maintenance." 1918 S.C. Acts 729, No. 398. Once the facility was built, the "Board of Regents shall notify the Governor, who shall thereupon by proclamation, declare the said Training School for the Feeble-minded ready to receive patients." *Id.* at 731, § 9.

The term "feeble-minded persons" was defined to mean "any moron, imbecile or idiotic person, of whatever grade, who is afflicted with mental defectiveness from birth or from an early age, so pronounced that he is incapable of competing on equal terms with his normal fellows or of managing himself or his affairs with ordinary prudence, and who, therefore, required custodial care and training for his own protection and for the welfare of others *and of the Community*, but who is not insane or of unsound mind. . . ." *Id.* at 731-32, § 10.

Institutionalization proceedings could be initiated by "any reputable citizen of this State" by filing "a petition in writing, setting forth that the person therein named is feeble-minded" and that it was "unsafe or dangerous to the welfare of the community for such person to be at large. . . ." *Id.* at 733, § 13.

State officials reported candidly to the General Assembly that the name of the facility was a misnomer since they "continue to forego" the provision of any "training of mental defectives" but "devote our efforts *mainly to seg-*

*regating* and giving physical care to as large a number as possible. . . ." FIFTH ANNUAL REPORT OF THE STATE TRAINING SCHOOL FOR THE FEEBLEMINDED, CLINTON, S.C., 1922, at 3 (1923).

As stated by Dr. B. O. Whitten, the Superintendent of the institution, "[i]n almost every instance the propagation of this element of society results in grief and disappointment to the persons in question and will scarcely ever operate in any way which can be expected to promote happiness *or even Anglo Saxon liberty.*" SIXTH ANNUAL REPORT OF THE STATE TRAINING SCHOOL FOR THE FEEBLEMINDED, CLINTON, S.C., 1923, at 12 (1924).

In 1935, the legislature authorized the "sterilization of mental defectives." 1935 S.C. Acts 428, No. 304.

**Tennessee.** On April 14, 1919, the General Assembly of Tennessee passed "An Act to provide for the protection, care, *control, oversight, custody, maintenance* and training of feeble-minded persons; to define who are feeble-minded within the meaning of this Act; and for the establishment, construction and maintenance of the Tennessee Home and Training School for Feeble-Minded Persons." 1919 Tenn. Pub. Acts 561, ch. 150. The Act applied to "any person with such a degree of mental defectiveness" as to be "a *menace to the happiness* or safety of himself *or of others in the community*" who "comprise those commonly called idiots, imbeciles, and morons or high-grade feeble-minded persons" and who "may or may not be subject to epileptic seizures." *Id.* § 2.

"Any relative of a feeble-minded person may make application to have the person so adjudged; but if the relatives and friends of any feeble-minded person shall neglect or refuse to place him or her in the Tennessee Home and Training School for Feeble-Minded Persons, or in a private institution for the feeble-minded, and shall permit him or her *to go at large*, then *any reputable person* being a resident of the county in which such feeble-minded person is found may make application for com-

mitment in writing and under oath to any one of the courts of his county, as above mentioned and shall not be subject to exception or demurrer for defects of form." *Id.* at 564, § 4. It was "the *special duty* of every county health officer and of every County Superintendent of Education in the State to file application for the commitment of feeble-minded persons whose parents or guardians neglect such duty . . . whenever such officer shall have reasonable cause to believe that such commitment is necessary to secure the welfare of such feeble-minded persons or of those persons with whom they come in contact." *Id.* § 5.

State officials acknowledged the legislation as a necessary enactment since "[o]f course, all will agree that there are very many feeble-minded in the State of Tennessee who have never gotten into one of the State institutions and are more or less a *menace and burden* to their respective communities." 1 Q. REP. ST. INSTITUTIONS 30-31 (1919).

**Texas.** Texas became the first southern state to segregate its retarded citizens when it opened in 1904 a special unit of the State Epileptic Colony, for "idiotic, imbecilic, and feeble-minded epileptics." Gaver, *Mental Retardation*, in MENTAL ILLNESS AND MENTAL RETARDATION: THE HISTORY OF STATE CARE IN TEXAS 20, 22 (1976).

In 1912, the Texas Conference on Charities and Corrections, which had been organized the previous year, presented in the last address of its annual conference a call by Professor Bird T. Baldwin of the University of Texas for an institution for the state's "mental defectives, who are *contaminating society by their presence*, absorbing time and thought that should be devoted to normal children, and later filling the almshouses, charitable institutions, and prisons with illegitimate and irresponsible offspring." Baldwin, *The Causes, Prevention and Care of Feeble-Minded Children*, in PROCEEDINGS OF THE STATE CONFERENCE OF CHARITIES AND CORRECTIONS AT ITS

SECOND ANNUAL MEETING HELD AT WACO, APRIL 14-16, 1912, at 86 (1912). According to Professor Baldwin, these "mental defectives or feeble-minded, who are *by-products of unfinished humanity, belong in an institution* where they may be cared for, made happy, and to some extent useful. They should be *segregated and not allowed to go to our schools with normal children* and should not be permitted to have offspring." *Id.* at 87-88.

The following year, the legislature heeded the call by enacting a bill establishing an institution for the "feeble-minded," but it was vetoed by the governor, apparently on budgetary grounds. This prompted a more concerted effort, again led by the State Conference on Charities and Corrections. Dr. C. S. Yoakum, Secretary of the State Conference, wrote a 156-page monograph calling for the enactment of this legislation. C. S. YOAKUM, CARE OF THE FEEBLE-MINDED AND INSANE IN TEXAS, BULL. U. TEX., NO. 369 (Humanistic Ser. No. 16, Nov. 5, 1914). The monograph called for the removal of "defectives" from the family since "[i]n a home where there is one feeble-minded child among a number of children, we have the definite effects of such communication. To be sure, we recognize the increase in sympathetic understanding that children and parents exercise toward such feeble-minded children; but these moral and social traits are infrequently developed and far overbalanced by the amount of time and energy required to care for such a child, especially if he be of the low grade imbecile or idiotic type. One writer states that we may figure without error that the time of one adult is needed for the care of every feeble-minded or low grade imbecile child or adult. In a custodial institution five of these defective children or adults may be cared for by a single attendant in a much better manner and with much better results than in the home. We are, then, by sending such children to institutions provided for their care, relieving four out of every five of the normal adults now busied in caring for such



defectives, for the economic and business life of the normal community." *Id.* at 44-45. Moreover, "[i]t is certain that the feeble-minded girl and boy are often the bearers of many of the social diseases, and it is especially true that feeble-minded girls are, in the large majority of cases, the inmates of our houses of prostitution." Thus, "the effect upon the community of the single individual of this type is bad in the extreme in so far as the social, economic, and moral ideals of that community are concerned." *Id.* at 45, 46.

According to Professor Yoakum, "[t]he only safe procedure is custodial and institutional care *throughout life* for the great majority. . . . Sterilization laws and other means of prevention must for years to come be secondary to this solution of the problem. *Id.* at 66.

The monograph set forth an extensive comparison of the various remedies to the "problem." "Restrictive marriage laws and customs are important, and educative, but fail to reach the irresponsible and degenerate till too late. The 'socially inadequate' are so named just because they are without the influence of law and order. Eugenic education, better environment, and systems of matings purporting to remove defective traits do not affect the impure blood and inheritable factors with the surety necessary to eliminate defects. Laissez-faire or natural selection, euthanasia, neo-malthusianism, and polygamy are either impossible under the protective forces of modern social conditions or are ideas repugnant to present-day ideals of religion and humanity." Of all the solutions, "[t]he evidence so far collected points toward *segregation* [emphasis in the original] as the most feasible, most easily put into force, and least subversive of constitutional prerogative." *Id.* at 82.

Yoakum quoted a report prepared by his parent organization to demonstrate the folly of the early approach taken by schools in the East: "A word to the West! . . . New States and communities should equip themselves properly to attack these problems, and should make their

plans on the basis of *complete control*. Had the States of the East followed this method during the last fifty years their burdens would be only a fraction as great as they now are." *Id.* at 17, quoting REPORT OF THE COMMITTEE ON PUBLIC SUPERVISION AND ADMINISTRATION TO THE NATIONAL CONFERENCE OF CHARITIES AND CORRECTIONS, SEATTLE, 1913, at 194 (1913). The bulletin concluded by stressing "the necessity for custodial care and oversight for *all* feeble-minded," through the enactment of legislation to "open[] the door of the institution to all feeble-minded of the State. . . ." *Id.* at 80, 83.

The State Conference meeting in San Antonio in November, 1914, presented additional papers. One concluded that "idiots" have "no economic value, and their care can only remain so much of a *dead load upon society*, whether cared for in a home or in an institution. They are, however, less expense in an institution than in the home, poor farm or asylum." Kelley, *The Colony Plan for the Care of the Feeble-Minded*, 2 BULL. TEX. ST. CONF. CHARITIES & CORRECTIONS 57, 48 (1915). Another concluded that "[f]or the actual idiot there is, or should be, no question as to procedure. The disease indicates its own remedy. The next legislature should make an appropriation for a permanent institution, in which these its most unfortunate citizens could be *permanently segregated*." Smith, *The Feeble-Minded Girls in the Virginia K. Johnson Home*, in *id.* at 61, 62.

Four months later, state representatives Ice Berg Reeves and D. S. McMillan had no difficulty convincing the legislature to reenact their H. B. No. 73, "An Act to provide for the establishment and maintenance of a State Farm Colony for the feeble-minded." 1915 Tex. Gen. Laws 143, ch. 90. With Governor Jim Ferguson's signature on the bill on March 22, 1915, Texas provided for "custodial care" for *all* of "the feeble minded of the State" to the end that these unfortunates may be prevented from reproducing their kind *and society relieved of the heavy economic and moral losses arising from the existence at*

large of these unfortunate persons." *Id.* §§ 1, 2. The colony opened on October 31, 1917. *Gaver, supra* at 24.

State officials, led by Superintendent J. W. Bradfield, urged the legislature to make it easier to populate the institution: "The female can, under the faulty labor conditions of today, make a living for a while, but she is, as a rule, quite unmoral, and makes no effort to protect herself. Her children, usually illegitimate, must, as degenerates, criminals, or defectives, eventually become wards of the State. The male moron is also a potential criminal, and is the class from which inmates for our jails and reformatories are recruited. *Their segregation and control, through life, is the remedy.* This can be obtained only by legally committing them to an institution where they can be kept permanently." In order to resolve this "most serious problem," he "urge[d] the enactment of an adequate commitment law." Bradfield, *Report of Superintendent, State Colony for Feeble-minded*, in FIRST ANNUAL REPORT OF THE STATE BOARD OF CONTROL TO THE GOVERNOR AND THE LEGISLATURE OF THE STATE OF TEXAS, FISCAL YEAR ENDING AUGUST 31, 1920, at 147 (1921).

The legislature responded favorably, enacting, by a unanimous vote, an act establishing a special "court for the feeble-minded" in each county. 1923 Tex. Gen. Laws 172, ch. 82, § 1. Authority was given to "[a]ny person who is a resident of the county having knowledge of a person in his county who appears to be feeble-minded" to petition to institutionalize that person. *Id.* § 2. "It shall be sufficient, if the affidavit shall be upon information and belief." *Id.* at 173. A hearing would then be scheduled by the court's issuance of an order "to show cause, if any, why such person should not be declared by said court to be feeble-minded. . . ." That order also was deemed to "be sufficient authority to the sheriff or any constable of the county to bring such feeble-minded person before the court for such hearing." *Id.* § 3. A jury could be demanded. *Id.* § 1. The finder of fact then "shall investigate

the facts and ascertain whether such alleged feeble-minded person is such." *Id.* § 4. "If it be found by the court or jury that the alleged feeble-minded person is such, the court shall enter its order so adjudging him, and that he be committed to the custody of the State Colony [sic] for the Feeble-minded," *id.* § 5, and "[a]ll persons heretofore or hereafter committed or admitted to such institution shall remain in its custody as permanent ward of the State until released by the management thereof," *id.* at 174, § 6.

As a result of the state's encouragement, the "demand for entrance into this institution . . . steadily continue[d] over our accommodations." THIRD REPORT OF THE STATE BOARD OF CONTROL TO THE GOVERNOR AND THE LEGISLATURE OF TEXAS, COVERING PERIOD FROM SEPTEMBER 1, 1924, TO AUGUST 31, 1926, at 9 (1927). According to Superintendent Bradfield "[t]his period has been marked by considerable growth of the institution, and we feel that we are now much better prepared to be of real service to the State. . . . These additions represent a healthy growth and encourage us in the belief that proper provision for the feeble-minded of the State is now being recognized as an absolute necessity." Bradfield, *Superintendent's Report*, in *id.* at 137, 138. In the same report, the Board of Control reported candidly that "[t]his institution is, of course, purely custodial. . . ." *Id.* at 9.

**Virginia.** On March 20, 1914, the General Assembly of Virginia enacted a law directing the State Board of Charities and Corrections to "investigat[e] . . . the question of the weak-minded in the State, other than insane and epileptic, and to report to the General Assembly of nineteen hundred and sixteen a comprehensive, practical scheme for the training, *segregation* and the prevention of the procreation of *mental defectives*." 1914 Va. Acts 242, ch. 147, § 1. Under the direction of its chairman, S. C. Hatcher, the Board published in 1915 a 128-page compilation of studies, recommendations, and pro-



posed legislation under the title of THE MENTAL DEFECTIVES IN VIRGINIA: A SPECIAL REPORT OF THE STATE BOARD OF CHARITIES AND CORRECTIONS TO THE GENERAL ASSEMBLY OF NINETEEN SIXTEEN ON WEAK-MINDEDNESS IN THE STATE OF VIRGINIA TOGETHER WITH A PLAN FOR TRAINING, SEGREGATION AND PREVENTION OF THE PROCREATION OF THE FEEBLE-MINDED.

A letter of transmittal from Chairman Hatcher to Governor Henry Carter Stuart accompanying the report stated that "the corrupt fruits of mental *degeneracy* in any community will disappear in proportion to the reduction of feeble-mindedness in that community . . . the most urgent need in the work of reducing degeneracy is the elimination of the feeble-minded." *Id.* at 5. Quoting approvingly eugenicist C. B. Davenport, Chairman Hatcher recommended that "[i]f the State were to segregate its feeble-minded, were to examine for mental defects all immigrants settling in its borders, and were to deport those found to be defective, there will be a constantly diminishing attendance at State institutions for the feeble-minded, and at the end of thirty years there would be practically no use for such institutions." *Id.*

The official report detailed numerous "case studies" to support its recommendations. For example, one such "feeble-minded" case "with certain facial lines make one feel that he is *not far removed from the brute*, and is perhaps cruel with the unconscious cruelty of an *animal*." *Id.* at 20. Another case "ha[d] not even the glimmerings of intelligence manifested by some of the lower forms of *animal life*." *Id.* at 41. Another had a wife who was already committed "in a suitable institution, but it seems a pity that the man, who is lower grade mentally than his wife, though not so much of a menace, cannot be *segregated instead of being allowed to run at large*. A larger and more adequate colony would remedy this." Noting that "the civilized nations of the earth are awakened to the menace of feeble-mindedness, and are taking

steps for the elimination and prevention of this evil, the report stated "that the principal things to be sought are *identification* and *control*, with the object finally of *elimination*; and so we will have to rely largely on *segregation* and education for the prevention of feeble-mindedness." *Id.* at 17. "[T]he main idea is to keep them healthy, happy, and out of mischief. [W]e must take our mental defectives back to the soil to get the best results." The report recommended that "the State should have authority to *segregate and to detain* mentally defective persons under proper conditions and limitations. This is in the nature of an *indeterminate sentence*, and is at the basis of the law which provides that the superintendent of the Virginia Colony for the Feeble-minded shall have authority to hold mentally defective persons *as long as he pleases*, and discharge such persons when he pleases. . . ." *Id.* at 114. In terms of those "at large," the State Board proposed that it "be empowered" to "have charge of the registration of the mentally defective persons of the Commonwealth" and to "have supervision of the care of such persons pending admission to institutions." *Id.* Additionally, "whenever, in the opinion of the said Board and the Division Superintendent of Schools, a child has proven to be a mental defective, the said Board should have authority, in its discretion, to transfer such child to the State School for the Feeble-minded." *Id.* at 117.

The General Assembly responded positively to the report, enacting the following March "An ACT to define feeble-mindedness and to provide for the examination, legal commitment, and the *custody and care of feeble-minded persons, and their segregation* in institutions." 1916 Va. Acts 662, ch. 388.

In 1924, the General Assembly passed "An ACT to provide for the sexual sterilization of inmates of State institutions." 1924 Va. Acts 569, ch. 394. This law, the constitutionality of which was upheld by the Supreme Court in *Buck v. Bell*, 274 U.S. 200 (1927), provided that

"whenever the superintendent" of "the State Colony for Epileptics and Feeble-Minded, shall be of opinion that it is *for the best interests* of the patients *and of society* that *any* inmate of the institution under his care should be sexually sterilized, such superintendent is hereby authorized to perform, or cause to be performed by some capable physician or surgeon, the operation of sterilization on any such patient confined in such institution afflicted with hereditary forms of insanity that are recurrent, idiocy, imbecility, feeble-mindedness or epilepsy." 1924 Va. Acts 569, § 1. The law was enacted, in part, for "the welfare of society." *Id.* (preamble). The law provided for an appeal to a special board, but such appeal was to be dismissed if it be found that the "feeble-minded" resident was "the probable potential parent of *socially inadequate offspring* likewise afflicted" and that "the welfare of the inmate *and of society* will be promoted by such sterilization. . . ." *Id.* at 570, § 2.

**West Virginia.** In 1917, Governor Henry D. Hatfield first called for the erection of "an institution" which would "provide for the *detention* and care of many feeble-minded persons now at large and would assist in solving the problem in this state in preventing the multiplication of such class." *Second Biennial Message of Governor H. D. Hatfield to the Legislature* (1917) in STATE PAPERS AND PUBLIC ADDRESSES OF HENRY D. HATFIELD 77 (n.d.)

"If such an institution should be authorized by the legislature, lands should be purchased to the extent of 500 acres upon which the institution should be erected. This would result in the institution becoming nearly self-supporting because of the fact that practically all of the inmates are able bodied and could perform any ordinary labor under competent supervision." *Id.* at 76-77.

In 1921, the Legislature of West Virginia created for "mental defectives" a state institution to be known as the "West Virginia Training School," for "any person" who "because of mental defect *is a menace to the happiness and welfare* of himself or herself or of others in the com-

*munity*, and therefore requires care, training or control for the protection of himself or herself or of others, and yet who is not insane. This type of persons, commonly classed as feeble-minded, including idiots, imbeciles and morons, shall be known and designated as mental defectives for the purposes of this act. Should the school at any time not be able to accommodate all persons of such class offered for admission, preference in admission shall be given to children and women of child-bearing age." 1921 W. Va. Acts 479-80, ch. 131, §§ 1, 3. "Any relative of a person affected may make application, by complaint under oath, to have the person adjudged a mental defective; *but when the relatives of a mentally defective person either neglect or refuse to place said person* in said school, or in some private institution of a like nature, and shall *permit him or her to go at large*, then *any reputable citizen* of the county may, by complaint under oath, make application to the mental hygiene commission for such commitment. . . ." *Id.* at 480, § 4(a).

The same law empowered the "medical staff" at the institution "to administer such medical treatment and perform such surgical operations for the inmates therein as may be necessary and expedient for the cure and prevention of mental defectiveness or disease." *Id.* at 482, § 5.

#### Western States

**Alaska.** Alaska's population was insufficient to justify a separate institution for retarded people in that state. In the territorial days, Congress authorized their commitment temporarily to the detention hospitals at Nome and Fairbanks until they could be transferred permanently to institutions in other states. See Pub. L. No. 216, § 7, 35 Stat. 601 (1909); Pub. L. No. 306, ch. 424, § 1, 36 Stat. 352 (1910).

**Arizona.** On April 20, 1927, the Legislature of Arizona established an institution for "mentally defective



children in the State of Arizona, which shall be known as the Arizona Children's Colony." 1927 Ariz. Sess. Laws 367, ch. 96, § 1. Such "defectives," the law mandated, "if not insane, *shall be held* and be determined to be mentally deficient, and be entitled to enter said colony." *Id.* at 369, § 10. Included among the considerations for determining mental deficiency was that the resident "require supervision, control, care and education, for their own welfare, or for the welfare of others, *or for the welfare of the community.*" *Id.* at 370, § 10(a).

**California.** On March 9, 1887, California became the first state to provide for the segregation, "for life," of "imbecile or feeble-minded" people. 1887 Cal. Stats. 69, ch. 57. The original funding for the facility, located in Santa Clara, had been authorized two years earlier. 1885 Cal. Stats. 198, ch. 156.

Because the state promoted segregation, the Santa Clara home grew quickly. By 1889, the institution was admitting not only severely retarded people, but also "cases well calculated to deceive the most observing." SONOMA STATE HOME, THE INSTITUTION BULLETIN (1910). Larger accommodations were soon needed. Therefore, on March 6, 1889, the state legislature appropriated \$170,000 to purchase land and "to erect proper and substantial buildings . . . upon said site." 1889 Cal. Stats. 69, ch. 75. The state purchased 1660 acres of land in a remote area near Eldridge in Sonoma County. By 1891 buildings were constructed and on November 24 of that year the residents were moved from Santa Clara. STATE BOARD OF CHARITIES AND CORRECTIONS, FIRST BIENNIAL REPORT 62 (1905).

State officials praised this development, noting that the "special province of the Home for the Feeble-Minded is to deal with the incipient aberration of the mental processes—striking at the cause. . . . This institution would *remove from society* the cause, so far as possible to do so." CALIFORNIA HOME FOR THE FEEBLE-MINDED, SIXTH ANNUAL REPORT 30-31 (1890). Indeed, there was

a felt need to track down the "very large class of those unfortunates for whom no application for admission into this institution has been made." *Id.* at 29.

On March 31, 1897, a law was passed amending the 1885 statute that had restricted admissions to those "feeble-minded children between the ages of 5 and 18 years . . . who are incapable of receiving instruction in the common schools." 1885 Cal. Stats. 198, ch. 156, § 8. Under the new law, the institution was "direct[ed] to admit" not only "idiots" but also "epileptics and mentally enfeebled paralytics . . . *irrespective of age*, as the accommodations of the home may permit, and as may, in the judgment of the management, appear suitable subjects for such admission." 1897 Cal. Stats. 251, ch. 188.

In its *First Biennial Report*, the newly created State Board of Charities and Corrections stated: "There are several reasons why the feeble-minded should be cared for in Homes of this sort. Their presence in the community at large is apt to be very detrimental to normal children, and when they come to the adolescent age the danger of reproduction in kind is very great and should, if possible, be prevented." FIRST BIENNIAL REPORT, *supra* at 41.

By the time of its Third Biennial Report, the State Board was stating unequivocally that there were "now in county hospitals, in orphan asylums, and other institutions, and *even in homes*, children who could be much better cared for in the State Home for the Feeble-Minded. Such a child is generally a *menace to the institution, the family, or the community in which he is*. It is desirable in every way to accept into the Home these children, as to *keep those who are now there.*" STATE BOARD OF CHARITIES AND CORRECTIONS, THIRD BIENNIAL REPORT 73 (1908).

In 1909, the California legislature became the second in the nation to vote into law "an act to permit asexualization of inmates of . . . the California Home." 1909 Cal. Stats. ch. 720.

## A-64/California

This law was progressively extended to cover more individuals by amendments of 1913 and 1917. The 1913 measure specified that sterilization could be performed "with or without the consent of the patient." 1913 Cal. Stats. ch. 363. The 1917 act extended the procedure to all persons deemed to suffer from "marked departures from normal mentality." 1917 Cal. Stats. ch. 489.

State officials also kept constant pressure on the legislature to provide increased appropriations to segregate more and more retarded persons, linking retardation with the immigration of "defectives." In 1915, an act was passed authorizing a legislative committee to investigate the necessity for a second mental retardation institution in the state. 1915 Cal. Stats. 1139, ch. 729. That committee found: "So fundamental is this problem of the feeble-minded that one can assert without fear of successful contradiction that if all the time, money and effort now devoted to the solution of all of our social problems were concentrated for the next ten years on the question of feeble-mindedness, there is not a social problem that would not be nearer its solution at the end of ten years than it will be under the present plan. The first step is to provide state colonies." LEGISLATIVE COMMITTEE ON MENTAL DEFICIENCY. REPORT ON MENTAL DEFICIENCY 22 (1917). The Committee further found, "[i]n considering the advantages of creating such an institution for the proper care of the mentally defective as unfortunate individuals, there is also to be remembered the benefit to society of thus being relieved of the menace of their unsocial conduct." *Id.* at 65. The Committee also recommended legislation "creating a new institution for feeble-minded and epileptic persons, to be located in Southern California." *Id.* at 63.

In the meantime, the State Board commissioned a series of "surveys in mental deviation" to bolster its case for another institution. Based upon the surveys it had commissioned, the Board reported a firm "*relation between race and mental deficiency.*" STATE BOARD OF

CHARITIES AND CORRECTIONS, EIGHTH BIENNIAL REPORT 51 (1918). One of the surveys, focusing upon the Merced County public schools, found that 4.24% of the students were "feeble-minded." CALIFORNIA BOARD OF CHARITIES AND CORRECTIONS, REPORT OF THE STATE JOINT COMMITTEE ON DEFECTIVES IN CALIFORNIA 27 (1918). This high number was explained by the fact that the county surveyed "possess[ed] an exceptionally high proportion of foreign-born in its population." *Id.* Since "of those found feeble-minded, 75.7% had foreign born parents," it was "evident, therefore, that *most of the feeble-mindedness in this country is due to the immigration of undesirable types.*" *Id.* at 35. Referring specifically to greater retardation it found among Mexicans and Portuguese, the report expressed "no wonder that these nationalities are present in the reform schools and state prisons in far greater proportions than their numbers in the state would seem to warrant." *Id.* at 35-36.

The survey found "the ratio of feeble-mindedness was far higher among Mexicans, Negroes, and recent immigrants from Europe than among those of native American stock," and concluded that "California has drawn a large proportion of immigrants of an undesirable type." *Id.* at 13-14, 19.

Referring to the survey of the Merced schools, the report found that the "hopelessly feeble-minded should be removed from the public schools and placed under permanent custodial care." *Id.* at 45.

The report "estimated the annual cost of feeble-mindedness in the State of California at \$5,000,000" including "relief for indigent and dependent defectives, expenditures for court proceedings and probation work for feeble-minded delinquents, depredations committed by defective delinquents, expense to the state of feeble-minded individuals in the prisons . . . and finally the money which is worse than wasted in the futile attempt to educate feeble-minded children. . . . We have not included in these estimates the losses accruing from



vocational unfitness, alcoholism, venereal disease, and prostitution among the defective population. It would not be surprising if these losses, although less tangible and altogether impossible to estimate accurately, were as great as all the other losses combined." *Id.* at 42.

The report noted the state's "awakening to the menace of the feeble-minded" as one of the most noteworthy movements of present public thought," *id.* at 5, and concluded that "[a]ll of the findings of this study emphasize the necessity of bringing a larger proportion of our defectives under social surveillance and restraint," *id.* at 19. Lamenting the fact that "California has but one state institution for the care of the feeble-minded," and arguing for the "permanent segregation of all feeble-minded individuals" and to "extinguish the defective strains which now encumber our prisons, reform schools, jails, courts, and public schools," the report urged as the "first step in this direction" the appropriation of funds for "the establishment of an additional state home for the feeble-minded." *Id.* at 51, 43.

The legislature in 1919 appropriated \$100,000, 1919 Cal. Stats. 1214, ch. 562, and, in 1921, \$120,000, 1921 Cal. Stats. ch. 445, for the construction of buildings at the "Pacific Colony." The facility opened on March 20, 1921. FIRST BIENNIAL REPORT OF THE DEPARTMENT OF INSTITUTIONS OF THE STATE OF CALIFORNIA 68 (1922).

In 1915, the legislature amended the law permitting the institutionalization of any "imbecile or feeble-minded person or any idiot" to the Sonoma State Home. The amendment added a proviso that, in addition to a parent or guardian, "any peace officer may petition said court for an order admitting such a person to such hospital." 1915 Cal. Stats. 1262, ch. 638.

State officials stated that the new law would "make it possible to secure the commitment of children who need institutional care but whose parents or guardians are averse to such action." STATE BOARD OF CHARITIES AND CORRECTIONS, BIENNIAL REPORT 30 (1916).

**Colorado.** On May 5, 1909, the General Assembly of Colorado established that state's institution "for mental defectives." 1909 Colo. Sess. Laws 180, ch. 71. The institution was opened on July 1, 1912, and its purpose from the outset was the "segregation, in an institution, for life," of the "defectives." FIRST BIENNIAL REPORT OF THE BOARD OF COMMISSIONERS AND SUPERINTENDENT OF THE COLORADO STATE HOME AND TRAINING SCHOOL FOR MENTAL DEFECTIVES, 1911-1912, at 5 (1912).

The program instituted by Colorado officials to enforce the state's new law was summarized in its *Second Biennial Report*: "The law of Colorado requires the legal commitment of all inmates to the State Home and Training School for Mental Defectives. This gives the management the control regarding the question of removal or discharge, and, in a limited sense, enables the institution to prevent this class of persons from coming in contact with the populace. It is impossible to restore feeble-minded persons to a normal condition, and by reason of this fact they should be kept in an institution indefinitely, and not be permitted to marry and perpetuate their kind. In years gone by, institutions for this class of persons took some pride in graduating as many as possible, and would turn them loose in the world to multiply; but this error is being corrected, as far as possible, by holding them indefinitely in institutions provided for their care and training." SECOND BIENNIAL REPORT OF THE BOARD OF COMMISSIONERS AND SUPERINTENDENT OF THE COLORADO STATE HOME AND TRAINING SCHOOL FOR MENTAL DEFECTIVES, 1913-1914, at 4-5 (1914).

By then, a peonage system had been established: "Many of the boys work on the farm and in the garden, in the laundry and in the kitchen. Girls and boys alike assist in making beds, sweeping, scrubbing floors, washing dishes, setting tables, and doing all kinds of housework. Some are capable of driving teams and can handle the hay-stacker quite skillfully. As the institution grows older, and more buildings are provided, and the popula-

tion increases, there will be enough boys who will become skilled by teaching and training to make the institution in a measure self-supporting." SECOND BIENNIAL REPORT OF THE BOARD OF COMMISSIONERS AND SUPERINTENDENT OF THE COLORADO STATE HOME AND TRAINING SCHOOL FOR MENTAL DEFECTIVES, 1913-1914, at 5 (1914).

**Hawaii.** On April 19, 1919, the Legislature of the Territory of Hawaii passed "AN ACT Providing for the Establishment and Maintenance of a Home for Feeble-Minded Persons." 1919 Haw. Sess. Laws 137, Act 102. The law specified custody, "said home [to be] conducted on the 'farm colony' plan." *Id.* § 2. The Home was open to all Hawaiians requiring institutionalization "for their own welfare, for the welfare of others, or for the welfare of the community." *Id.* at 138, § 4.

The institution was "considered merely a place to get the feeble-minded out of the community. . . ." DEPARTMENT OF INSTITUTIONS, TERRITORY OF HAWAII, THE FIRST TEN YEARS, 1939 THROUGH 1949, at 37 (1949).

**Idaho.** The "Idaho State Sanitarium" for "the feeble-minded" was established in 1911 by enactment of the Legislature of Idaho. 1911 Idaho Sess. Laws 86, ch. 41. Upon a finding that a person was "feeble-minded," according to the state, a judge "must issue and deliver to some peace officer for service a warrant directing that such person be arrested and taken before any Judge of a Court of record within the county for examination." *Id.* at 94, § 33.

In 1921, it was explicitly mandated that the institution be used for confinement of those "merely defective from birth and not insane, irrespective of age, who are legal residents of the state, and who are from a social standpoint dangerous to be at large and a menace to society." 1921 Idaho Sess. Laws 326, ch. 139, § 1.

To assist in the elimination of this "menace," the legislature adopted "AN ACT TO CREATE A STATE BOARD OF EUGENICS; TO PROVIDE FOR THE

STERILIZATION OF ALL FEEBLE-MINDED . . . WHO ARE A MENACE TO SOCIETY." 1925 Idaho Sess. Laws 358, ch. 194. The law "declared the duty" of the superintendent of the Idaho State Sanitarium to register with the new Board of Eugenics "all persons, male or female, who are feeble-minded . . . who are, or in their opinion are likely to become, a menace to society." *Id.* at 359, § 2. "[I]f in the judgment of a majority of said Board procreation by such person would produce a child or children having an inherited tendency to feeble-mindedness . . . or who would probably become a social menace or ward of the State, and there is no probability that the condition of such person so investigated and examined will improve to such an extent as to avoid such consequences, then it shall be the duty of such Board to make an order embodying its conclusions with reference to such a person in said respects and specifying such a type of sterilization as may be deemed by said Board best suited to the condition of said person and most likely to produce the beneficial results in the respects specified in this section." *Id.* One of the "objects to be sought" by this chapter was "to protect society from the acts of such person, or from the menace of procreation by such person." *Id.*

**Montana.** On March 4, 1919, the Legislative Assembly of Montana passed "An Act Relating to the Admission, Care and Retention of Feeble-Minded Persons." 1919 Mont. Laws 196, ch. 102. The law established the "Montana Training School for Feeble-Minded Persons" for the "detention" of "feeble-minded minors and adults." *Id.* § 1. The law also provided that "no inmate may be removed from said institution, permanently or temporarily, except upon a written order of the superintendent or upon an order of any District Court of the state and the provisions of this Section shall apply to adults as well as to the minors therein. The costs of such court action to be borne by the party bringing the action." *Id.* at 198, § 9.



Four years later, the lawmakers authorized surgery that would "surely and permanently nullify the power to procreate offspring, to achieve permanent sexual sterility" of the "feeble-minded," 1923 Mont. Laws 535, ch. 164, § 2(e), with the purpose of "protect[ing] society from the menace of procreation by said inmate," *id.* at 537, § 8.

**Nevada.** Nevada, like Alaska, did not have sufficient population to support its own institution. For this reason, the legislature authorized state officials "to make arrangements with the director of any institution for the feeble-minded in California, or Utah, or other states" for Nevada's "feeble-minded." 1913 Nev. Stats. 576, ch. 287.

**New Mexico.** On March 20, 1925, the Legislature of New Mexico mandated that "[t]here shall be established and hereafter maintained by this State an institution to be known as The Home and Training School for Mental Defectives," for "any person mentally underdeveloped or *faultily* developed" who "requires supervision, care and control for his own welfare, or for the welfare of others, or for the welfare of the community, and which mentally defective person is not classified as an insane person." 1925 N.M. Laws 254, ch. 133, §§ 1, 2. Commitment proceedings could be initiated by "[a]ny person over the age of twenty-one years" by alleging "the facts bringing each person within the provisions of this Act and shall state the name and place of residence of such person. . . ." *Id.* at 255, § 5. "The superintendent, with the approval of the Board, may give preference to cases which constitute a *special social menace.*" *Id.*

**Oregon.** Before authorizing the establishment of a segregative institution, the Oregon Legislative Assembly ordered a formal study. The report that issued indicated that the reason "for custody of feeble-minded" that "outweigh[ed] all others in importance to the State" was that the "*effect of the mingling of the feeble-minded with society is a most baneful evil.*" REPORT OF THE BOARD OF BUILDING COMMISSIONERS OF THE STATE OF OREGON

RELATIVE TO THE LOCATION AND ESTABLISHMENT OF AN INSTITUTION FOR FEEBLE-MINDED AND EPILEPTIC PERSONS, TO THE TWENTY-FOURTH LEGISLATIVE ASSEMBLY, REGULAR SESSION, 1907, at 22, 23 (1906). "Once admitted, they remain at the institution *for life.*" *Id.* at 37. The Legislative Assembly followed the recommendation of the report when, on February 23, 1907, it passed "AN ACT Creating the State Institution for Feeble-Minded," for the "care and custody of feeble-minded, idiotic, and epileptic persons." 1907 Or. Laws 145, ch. 83, § 1. The facility was for "all idiotic and epileptic persons" residing in the state for at least a year. *Id.* at 146, § 8.

In 1917, the Legislative Assembly enacted a more sweeping law: "The county judge of any county of this State shall, upon the application of any citizen in writing, setting forth that *any person* over five years of age is *feeble-minded* or who, by reason of feeble mindedness, is criminally inclined, or is unsafe to be at large, or may procreate children, *cause such person to be brought before him* at such time and place as he may direct . . . Such judge, if in his opinion said person is feeble-minded, shall commit said person to the Institution for the Feeble-minded of the state of Oregon for *indeterminate detention.* . . ." 1917 Or. Laws 739, ch. 354, § 1. The same law required that "[a]ll county superintendents of schools shall make reports on the first of June and the first of December of each year to the county courts of their respective counties which report shall contain the names and addresses of all scholars in the public schools and of *all children* of school age in their respective counties who are mentally defective. . . ." *Id.* at 740, § 5.

Soon thereafter, the lawmakers installed a "state board of eugenics," and "declared the duty" of "the superintendent of the state institution for feeble-minded" to "report," on a quarterly basis to the board "all persons, male or female, who are feeble-minded" that "are, or in his opinion are likely to become, a menace to society." 1923 Or. Laws 280, ch. 194, §§ 1, 2. The board's "duty"

was to review the superintendent's opinion and, if in agreement, order sterilization. *Id.* at 280-81, § 3. If the resident failed to consent to the surgery, "such operation shall thereupon be performed upon said person by or under the direction of the superintendent of the institution." *Id.* § 6.

**Utah.** The "Utah State Training School for Feeble-minded" was established in 1929 for "all feeble-minded persons who are residents of the State, whose defects prevent them from properly taking care of themselves or who are a social menace." 1929 Utah Laws 102, 108, ch. 75, § 22.

Commitment proceedings could be initiated by "any person" by alleging that someone in the community "by reason of feeble-mindedness is a social menace." *Id.* at 110, § 23(3). "Upon receipt of such application, duly signed and acknowledged, the clerk of the district court shall present the same at the earliest date, and the judge of the district court shall issue a warrant to the sheriff of the county to produce the person described in such application before the court forthwith for examination." *Id.* at 112. If the court "believes" that such person is, "by reason of feeble-mindedness, a social menace" then it "must make an order that such person be confined in the Utah State Training School." *Id.* at 113, § 29.

The same legislation required that "any patient" at the institution "should be sexually sterilized" by "the operation of sterilization or asexualization." Such surgery was to be performed "[w]hensoever the Superintendent and board of trustees of the Utah State Training School shall be of the opinion that it is for the best interests of the patients and of society." *Id.* at 115, § 31.

The state institution was soon filled to capacity. By 1938, the Board of Trustees was able to report to the legislature and the Governor that "[t]he physical growth of the Utah State Training School and the scope of its service to the State of Utah must be recognized as having removed all possible doubt or question as to the funda-

mental necessity of maintaining such an institution as a part of the broad program of education and social regulation and control." FOURTH BIENNIAL REPORT OF THE BOARD OF TRUSTEES OF THE UTAH STATE TRAINING SCHOOL, AMERICAN FORK, UTAH, TO THE GOVERNOR AND LEGISLATURE FOR THE BIENNIUM ENDING JUNE 30, 1938, at 3 (1938). "The many actual experiences of the board since the school was established has demonstrated that *the presence of a feeble-minded child in a home is more depressing, expensive and tragic than any known disease. Mental defect vitiates the offspring, and wounds our citizenry a thousand times more than any plague man is heir to.* Even though this grief is often veiled with a smile, it destroys, demoralizes and sets as naught the lives of too many of our people. The Board of Trustees has considered the so-called South Dakota plan by which responsibility is divided among the different community organizations and state agencies, but all with *the ultimate purpose of segregating, supervising, and then sterilizing certain of the mentally deficient within the state.*" *Id.* A major outreach effort was undertaken with the support of the state agency: "Under the welfare program as now operating, community welfare workers are cooperating with the schools in the various communities and in this way many of the mentally deficient *who have heretofore been overlooked and held as problems to their families and immediate neighbors only, are now detected* and the necessity recognized for some action to prevent their continuing as a menace. . . . *When once they are detected and their status is known, proper protection to society requires that they be segregated and supervised, at least until they are sterilized.*" *Id.* at 5.

**Washington.** In 1905, the Legislature of the state of Washington adopted as an emergency measure "AN ACT providing for the care of defective and feeble minded youth, establishing an institution therefor." 1905 Wash. Laws 133, ch. 70. The law made it "the duty of the clerks of all school districts in the State of Washington at the



time of making the annual reports, to report to the school superintendent of their respective counties the names of all feeble-minded youth residing within their respective districts." *Id.* at 135, § 7. The school superintendents, in turn, were required to annually "report to the State Board of Control" those names. *Id.* at 134, § 4.

The law stated, flatly: "It shall be *the duty* of the parents or guardians of such defective youth to send them to the said institution for feeble-minded." *Id.* at 135, § 9. Moreover, the legislature made it *a crime* for the parents to fail to follow this "duty": upon their failure to send their child to the state institution, the parents "shall be *deemed guilty of a misdemeanor*, and upon conviction thereof, upon the complaint of any officer or citizen of the county or state, before any justice of the peace or superior court, *shall be fined in any sum not less than fifty nor more than two hundred dollars* in the discretion of the court." *Id.*

A 1909 amendment to the law provided that "children who are idiotic, epileptic or afflicted in any particular that renders them *unfitted for companionship with other children shall be segregated*. . . ." 1909 Wash. Laws 260, tit. I., subch. 6, § 2.

In 1913, the legislature changed the name of the state institution to the "State School and Colony," and provided that commitment proceedings could be initiated, without the consent of the parents, by the superintendent of the institution and by county superintendents of schools, and by county commissioners. 1913 Wash. Laws 598, ch. 173, §§ 1, 2. The law provided that "[c]ounty superintendents of schools shall cause to be filled out the prescribed blank applications for admission for such children in their respective districts, who by reason of mental or physical defects are incapable of receiving instruction in the common schools of this state, *or whose habits are such as to render them unfit for companionship with normal children*." *Id.* at 598-99, § 4. The law also eliminated a restriction in the prior law limiting admissions to

those under twenty-one years of age. *Id.* at 599-600, §§ 8, 9. In accord with the real purpose of the facility, the name was changed once again, this time to "The State Custodial School." 1917 Wash. Laws 224-25, ch. 64.

In 1921, the lawmakers passed "AN ACT to prevent the procreation of feeble minded," which "declared the duty" of the superintendent of the state institution "to report to the Board of Health 'all feeble minded . . . who are persons potential to producing offspring who, because of inheritance of inferior or anti-social traits, would probably become a social menace or wards of the State.'" 1921 Wash. Laws 162, ch. 53, § 1. The Board was given "the duty," following an investigation and a hearing, to "make an order directing the superintendent of the institution in which such inmate is confined to perform or cause to be performed upon such inmate such a type of sterilization as may be deemed best by said Board," with the only proviso being that "no person shall be emasculated under the authority of this act except that such operation shall be found to be necessary to improve the physical, mental, neural or psychic condition of the inmate." *Id.* at 163-64, §§ 2, 3.

**Wyoming.** On February 18, 1907 the Legislature of Wyoming "established in this state an institution for the custody, care, education, proper treatment and discipline of feeble-minded and epileptic persons, under the name and style of the "Wyoming Home of the Feeble-Minded and Epileptic." 1907 Wyo. Sess. Laws 188-89, ch. 104, § 1. The institution was created for "[a]ll feeble-minded and epileptic persons over the age of six years, who are legal residents of the State of Wyoming." *Id.* at 190, § 9.

Four years later, the name was changed to the "Wyoming School for Defectives," 1911 Wyo. Sess. Laws 166-67, ch. 103, § 1, and an involuntary commitment procedure was established, *id.*

In 1929, the legislature expanded the law to permit the initiation of commitment proceedings by the "pros-

ecuting attorney of the county in which hearing under this Act is proposed to be held, or by *any* citizen of Wyoming," 1929 Wyo. Sess. Laws 156, ch. 95, § 16, and the person to be committed was given the right to demand a jury trial, *id.* at 158, § 20.

### District of Columbia

The segregation of retarded people in the District was encouraged and required by the executive and legislative branches of the United States in those days preceding District home rule. The earliest involvement of the United States occurred when, in the nineteenth century, "certain feeble-minded children were taken in charge from time to time by the Secretary of the Interior" and sent to the Pennsylvania Training School at Elwyn. CHARITABLE AND REFORMATORY INSTITUTIONS IN THE DISTRICT OF COLUMBIA: HISTORY AND DEVELOPMENT OF THE PUBLIC CHARITABLE AND REFORMATORY INSTITUTIONS AND AGENCIES IN THE DISTRICT OF COLUMBIA. S. DOC. NO. 207, 69th Cong., 2d sess. 326 (1927).

At the turn of the century the prevailing public sentiment had become one of intolerance. The District Board of Charities in its 1902 Annual Report first called for the establishment of an institution for the District. "Many of the class of children referred to remain children permanently, regardless of their age, and it is important that they should be under custodial care, because of the great menace to the community involved. . . ." S. DOC. NO. 207, *supra* at 327. In 1907, the Board of Charities again stated that it could "not too strongly emphasize the importance of the *permanent segregation* of this class." *Id.* at 328. By 1913, the language of the Board's recommendation had become more urgent yet: "While institutions for the care of the feeble minded are usually designated as 'schools,' it must not be forgotten that many of this class *should be segregated* and under supervision *during their entire lives*, and most of them should *never be al-*

*lowed at large.* . . . We recommend, therefore, that steps be taken as soon as possible looking to the acquirement of a tract of land and the establishment thereon of a suitable institution for the care and training of the feeble-minded and the *permanent segregation* therein of such of them as are *unfit to be at large in the community.*" *Id.* at 329-30. The Monday Evening Club formed a committee to persuade Congress of the need for "[s]egregation of the adult feeble-minded." *Urges Institution for Feeble-Minded*, Wash. Star, Nov. 18, 1913, at 9.

The United States Department of Labor, through its Bureau of Children's Services, undertook a comprehensive "study of the extent of the problem of mental defectiveness in the District of Columbia," as the Department explained in the introduction to its report, "at the request of a citizen committee . . . organized under the leadership of the Monday Evening Club, [and] composed of representatives of various philanthropic and social agencies and institutions of the District whose dealings with the problems of the community have made them realize the urgent need for securing an institution for the proper care and treatment of mental defectives." U.S. DEPARTMENT OF LABOR, MENTAL DEFECTIVES IN THE DISTRICT OF COLUMBIA: A BRIEF DESCRIPTION OF LOCAL CONDITIONS AND THE NEED FOR CUSTODIAL CARE AND TRAINING 7 (G.P.O. 1915). Federal employees at the Department gathered data regarding "the danger to the *whole community* resulting from the lack of proper provision for those suffering from mental defect." *Id.* at 8.

Under a chapter entitled "reasons for segregation," the Department of Labor listed a number of considerations it thought important. For example, "[a] mentally defective child in a family demands a large share of the energy of the mother and not only interferes with the training of the other children but exercises a *demoralizing influence on the family life.*" *Id.* at 20. The "mentally defective" were also a "danger to society": "The number of mental defectives among recidivists empha-



sizes the need of discovering mental defect early in the careers of delinquents and *segregating them permanently* for their own welfare *and for the protection of society*. . . .” *Id.* at 21. Only “[b]y means of *segregating mental defectives* it is possible to cut off at the source a large proportion of degeneracy, pauperism, and crime.” *Id.* Indeed, the Department of Labor expressed concern that “[m]any children . . . now in the schools constitute a menace to the other pupils.” *Id.* at 18. Thus, according to the federal agency, “[i]nstead of being regarded as an individual misfortune, mental defect has come to be recognized as a destructive social force.” *Id.* at 20.

The Department of Labor acknowledged that the establishment of the institution for the District of Columbia would create its own demand: “[T]he number of inmates will increase as the institution becomes better established and as the public becomes familiar with its purposes and the value of its work to those cared for *and to society*. It has been said that the presence in a community of any specified type of defectives becomes apparent only when accommodations are provided for the care of this particular class. Without question this will be found to be the situation in the case of mental defectives.” *Id.* at 19. But it would be “out of the question to provide separate institutions for the different types of mental defectives.” *Id.* at 24. Referring to the “*various grades*” of “idiot,” “imbecile,” and “moron,” *id.* at 8, 24, the Department recommended that the facility “be large enough to provide the necessary room for *all these classes*, allowing for proper separation of white and colored, male and female,” *id.* at 24. The report of the United States Department of Labor concluded by quoting approvingly from an editorial in *Survey* magazine (March 2, 1912): “The greatest need of all is for *more institutional care*. When this has been brought about *in every State* we shall witness a great gaol delivery. . . . Biology and economics unite in

*demanding* that the strains of *feeble-mindedness* shall be eliminated by the humane segregation of the mentally defective.” *Id.* at 28.

The Congress responded to the Department of Labor’s strong recommendations, when it “authorized and directed” the District Commissioners “to use a site for a home and school for feeble-minded persons, said site to be located in the District of Columbia. . . .” P.L. No. 67-256, 42 Stat. 39 (1922). The Board of Charities, while generally pleased that Congress had acted, noted that the proviso that the institution be located within the District was “a fatal error” in the enactment. REPORT OF THE BOARD OF CHARITIES OF THE DISTRICT OF COLUMBIA 9 (1922). According to the Board, it would be far better to locate the institution “away from thickly settled communities” since “[f]or these unfortunates, children in mind but many of them old in years, all that society can do is to provide humane and sympathetic care *apart from the excitement and complexities of modern life*.” *Id.* at 10.

In 1923, the Executive Secretary of the Board of Charities, George S. Wilson, accompanied by five other members of the Board, appeared before the Senate Committee on the District of Columbia to express their concern over the specified location of the institution. Wilson testified that “there is a unanimity of opinion on the part of the people of the District of Columbia on this item, greater than we have ever seen exhibited in regard to any matter of great public interest. It is not only the medical and social, and the general welfare organizations, but it is the civic associations and the Board of Trade and other organs of public opinion. At this moment the Board of Trade is circulating among its members a petition, and the Monday Evening club and other bodies are circulating similar petitions, and we are all very much concerned about it.” *District of Columbia Appropriations Bill, Hearings Before the Comm. on Appropriations, 67th Cong., 2d sess. 94-98, 183-84 (Jan. 13, 15, 1923).*

## A-80/District of Columbia

In response to questioning by the Senators, Wilson explained further "the difficulties that they have in all these other States. I have just come from a visit to the Michigan school. They have the low-grade idiot, *which the Senator knows is not much above the animal*. They have the imbeciles; *that term is almost self-explanatory*. They have the higher grade, the dangerous cases, the morons, *the fellows that set fire to buildings, and the women who have illegitimate children*. There are at least three classes that no persons having humane instincts would classify together. Those three, multiplied by two to separate the sexes, make six; and then we have to multiply by two to provide for the separate colors here, which makes a minimum of 12 groups of these dependent people that we must provide for—helpless and dependent—and above everything else *unable to associate safely with normal people. Isolation is demanded, absolutely*, and the only thing we can promise to put into their lives is humane segregation in the open air." *Id.* at 96. Wilson concluded his testimony by emphasizing that it was "the segregation from society that is the best of things." *Id.* at 183. Senator Ball commented, "[i]f you are going to segregate that class of people to make them more content, you want a farm entirely separate."

The following year, the Congress "authorized and directed" the District Commissioners "to acquire a site for a home and school for feeble-minded persons, said site to be located in the District of Columbia or in the State of Maryland or in the State of Virginia, and to erect thereon suitable buildings at a total cost not exceeding \$300,000. . . ." P.L. No. 67-457, 42 Stat. 37 (1923).

On March 3, 1925, the Congress enacted "An Act to provide for commitments to, maintenance in, and discharges from the District Training School. . . ." P.L. No. 69-578, 43 Stat. 1135 (1925). The law defined "feeble-minded persons" to include "any person afflicted with mental defectiveness from birth or from an early age, so pronounced that he is incapable of managing himself and

his affairs, or being taught to do so, and who requires supervision, control, and care for his own welfare, or for the welfare of others, or *for the welfare of the community*, and is not insane or of unsound mind. . . ." *Id.* § 2. Congress gave "*any reputable citizen* of the District of Columbia" the authority to initiate commitment proceedings, *id.* § 7, and "if it shall be made to appear to the court by evidence given under oath that it is for the best interest of the alleged feeble-minded person or of other persons or of the community that such person be at once taken into custody . . . *id.* § 10, 43 Stat. at 1136.

A week later, on March 10, 1925, the institution, located at Annapolis Junction, "midway between Baltimore and Washington" began operation when "10 boys were received," housed in a "temporary building." REPORT OF THE BOARD OF CHARITIES OF THE DISTRICT OF COLUMBIA 2 (1925). They were immediately put to work: "The boys thus far have been engaged in clearing and grading for the location of buildings, repairing roads, digging trenches, etc., and in general farm work. A good garden was started in time to supply vegetables in abundance during the summer. An encouraging beginning has been made in actual farm work; 60 acres of corn were planted and a good yield will furnish sufficient grain and forage for the stock, chickens, hogs, etc., during the coming winter. Enough potatoes have been raised also to meet the institution needs until next spring." *Id.*



## **APPENDIX B**

**I. THE CLEBURNE ORDINANCE IS PART OF A PATTERN OF STATE-IMPOSED, LIFE-LONG SEGREGATION OF RETARDED PEOPLE THAT IN ANIMUS AND PURPOSEFUL UNEQUAL TREATMENT IS PARALLEL TO THE TREATMENT OF BLACK PERSONS.**

The decades at the turn into this century imposed a stark legacy upon the country. The xenophobic hysteria of the era, fueled by the new scientism of the eugenics movement, possessed by severe Darwinian strictures and doubts, assaulted by the unprecedented flow of new immigration and the uncertainties of a new industrial age, took on all the force of state power and focused it pervasively against black people and against retarded people and visited upon them the most severe disqualifications imaginable among citizens.

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discourse met "this very difficulty at the outset":

"We soon realized that having in one of these groups that test to the mentality of say an eight-year-old normal child, we were facing a very interesting problem, as to what was the difference between children who had lived in the world twelve years, and those who had lived twenty years . . . . In other words, a child who tests according to the Binet test, ten years of age, but is actually fifty years old, may be expected to do a great many things which will quite surprise us because we never have happened to know of a ten-year-old child that could do those things . . . ."

Goddard's solution to the measurement difficulty?

"[I]n order to get some accurate idea as to what mental age meant . . . . we had to cut out all those who were beyond the training period [i.e., those over twenty years]."

Thus Goddard "validated" — and the Era installed and perpetuated in the common prejudice — a measure that does not measure. Goddard, *Four Hundred Feeble-Minded Children Classified By the Binet Method*, 15 J. PSYCHO-ASTHENICS 13 (1910). Others made the point, for example, Kuhlman, *Degree of Mental Deficiency In Children As Expressed By The Relation of Age To Mental Age*, 17 J. PSYCHO-ASTHENICS 132 (1913):

"Feeble-mindedness is a retarded *rate* of mental development. The term 'arrested development' or 'mental arrest' is a misnomer, for it implies that development has ceased. It is a common observation that feeble-minded children do develop mentally. We also find that their mental ages as measured by the Binet-Simon tests increase as they grow older."

But it is the "ceiling" idea of "mental age" that was codified into invidious



The Jim Crow system segregating people by race was not a 19th century invention, but a creation of this era. C. V. WOODWARD, *THE STRANGE CAREER OF JIM CROW* (3d rev. ed. 1974). Similarly, large, isolated institutions that separate retarded people from the wider society for life are an invention of this era. Like Jim Crow, these institutions were created by state law *intentionally* to segregate retarded people. Thus a regime of state-imposed life-long segregation of retarded people was commissioned, and public, as well as private, attitudes and action that would reinforce it were legitimated and evoked.<sup>6</sup> This case will determine whether it shall be disestablished.

In Texas, Jim Crow was enacted and in force in the first decade of this century.<sup>7</sup> Texas created its first institution "for the feeble-minded" of the State by Act of March 22, 1915.<sup>8</sup> Section 2 of the Act declared as its purpose to end "the heavy economic and moral losses arising from the existence at large of these unfortunate persons." The Superintendent of the State Colony for the Feeble-Minded reiterated its purposes in his Third Annual Report:

"[T]heir segregation and control, through life, is the remedy. This can be obtained only by legally committing them to an institution where they can be kept permanently."<sup>9</sup>

stereotype, to wit: The January 7, 1985 *Dallas Morning News* (17A, col. 1) opened a six-column feature story with lead paragraphs saying:

"Sarah is three years old — forever.

"She was born 26 years ago, but something went wrong, and her mind stopped growing at the mental age of three."

6. The exclusion in the Cleburne ordinance at issue here did not first appear in the Cleburne zoning ordinance in 1963 as petitioners have incorrectly asserted throughout. The exclusion of "feeble-minded patients" appeared first in the Cleburne ordinances in 1947. It was taken verbatim from the September 11, 1929 ordinance of the City of Dallas. The relevant portions of both ordinances are reproduced at Appendix B.

7. See, e.g., 1907 Tex. Gen. Laws 58.

8. "An Act to Provide for the Establishment and Maintenance of a State Farm Colony for the Feeble-Minded and to Make Appropriations Therefore, and to Declare an Emergency." 1915 Tex. Gen. Laws 143, ch. 90.

9. *Superintendent's Report* (August 31, 1920) in FIRST ANNUAL REPORT OF THE STATE BOARD OF CONTROL TO THE GOVERNOR AND THE LEGISLATURE OF

The animus of the Act creating the State Colony to segregate retarded people is set forth in a 1914 pamphlet of the Texas State Conference on Charities and Corrections.<sup>10</sup> The pamphlet opens:

"Every state, to maintain the highest efficiency in its governmental and social functions, must consider the nature of its citizens. We are in the habit of dividing citizens into two classes based on their value to society or their amenableness to social custom and law — desirable and undesirable citizens. The latter class comes in conflict with law and is generally considered a menace to good government." *Id.* at 11.

It continues:

"The general public has already been educated to the belief that it is a good thing to segregate the idiot or the distinct imbecile, but they have not, as yet, been quite so fully convinced as to the proper treatment of this brighter and more dangerous class, the defective delinquent. From a financial standpoint, segregation of the defective delinquent would be a great economy, to say nothing about the more salient feature, that of stopping them from producing their kind. If we could segregate these defectives when they are young and keep them confined during their natural lives, it would

THE STATE OF TEXAS 147 (1921) (Docs. Coll. Tex. St. Archives).

10. C.S. YOAKUM, *CARE OF THE FEEBLEMINDED AND INSANE IN TEXAS*, BULLETIN OF THE UNIVERSITY OF TEXAS, NO. 369 (Humanistic Ser. No. 16, Nov. 5, 1914) (on file in Pamph. Coll., Tex. St. Archives, Austin, Tex.). The pamphlet originated as a committee report of the State Conference on Charities and Corrections, which, like conferences in other states and the National Conference on Charities and Corrections, was composed of leading citizens, most often drawn from the leading families — professors, journalists and public officials, including mayors and legislators — and was the active progenitor of the Act of March 22, 1915, as it had been of the juvenile court law, the suspended sentence law and other Progressive Era legislation.

"It aims to bring together for a free exchange of views and experiences for united action all persons and all organizations and institutions, public and private, engaged or interested in work of a charitable or philanthropic character, or in administering our penal and correctional institutions and agencies."

PROCEEDINGS OF THE STATE CONFERENCE ON CHARITIES AND CORRECTIONS 11-12 (1912) [hereinafter cited as PROCEEDINGS].

obviate the expense of having them committed repeatedly to our penitentiaries when they grow older. . . .

"Some may say, 'Why it is a pity to confine these children in an institution all their lives'; but that is where they are greatly mistaken, as for instance, in Ohio, I can say to you that we have a community of over 1600 of the happiest children in the State in our institution.' . . . " *Id.* at 46.

The pamphlet goes on to warn:

"To discharge, unsterilized, the defective child, after having taught him habits of neatness and a few tricks that make his mental deficiency less noticeable, is worse than never to have put him in an institution.' In other words, the defective is a person who, for the good of society, must end his line of descent with himself. We have indicated in other places that he is personally a menace to society while alive.

"The only safe procedure is custodial care and institutional care throughout life for the great majority. Some authorities believe that a small percentage of those who are trainable may after a time be returned to society. Even these are usually far better off in an institution where they can earn a living under watchful care. In the paragraphs that follow, we shall describe the type of institution that is best suited to such lifelong protection of these derelicts in society." *Id.* at 66.

The pamphlet concludes:

"A clean-limbed, pure-minded, sane thinking people is an ideal alone commensurate with the ideals of this State and this nation. What shall we do to attain, to eliminate this great and ever-increasing source of ignorance, poverty, and crime? 'One of the most shocking and easily cured evils is the increase of the feeble-minded, the begetters of numerous degenerate children. The remedy is their segregation by the State . . . ' The answer comes with no uncertain ring.

"This problem of racial betterment is called in modern phrase, eugenics. Our purpose in this discussion has been limited. We have, therefore, discussed the single phase of

the general problem — the elimination of the defective strains. Many answers and solutions have been offered, among them segregation has appealed to society's feelings of humanity and fair play with greatest force. Restrictive marriage laws and customs are important, and educative, but fail to reach the irresponsible and degenerate till too late. . . . Laissez-faire or natural selection, euthanasia, neo-malthusianism, and polygamy are either impossible under the protective forces of modern social conditions or are ideas repugnant to present-day ideals of religion and humanity. Of all the solutions suggested, the two most advocated are sterilization and segregation. Both of these ideas were embodied in bills submitted to the last Legislature in Texas.

"The evidence so far collected points toward *segregation* as the most feasible, most easily put into force, and least subversive of constitutional prerogative. . . ." *Id.* at 81-83 (pamphlet's emphasis).<sup>11</sup>

This Texas undertaking by force of law of the life-long segregation of retarded persons was universal among the states.<sup>12</sup> Each of the states resolved, *de jure*, as did Pennsylvania:

"that the Eastern Pennsylvania State Institution for the Feeble-Minded and Epileptic shall be devoted to segregation, care, maintenance, treatment, training and education of epileptic, idiotic, imbecile or feeble-minded persons,"

1913 Pa. Laws 494, No. 328, § 1; and as did Florida:

"that there is hereby established . . . a Florida Farm Colony for Epileptic and Feeble-Minded . . . for the segregation and employment of the epileptic and feeble-minded . . . to the end that these unfortunates may be prevented from reproducing their kind, and the various communities and the

11. A second, separate section of the Texas pamphlet, addressing care of "the insane" (*id.* at 84-145), reflects confusion of the two (109-128), but nowhere calls for, but rather rejects (100, 136-37) permanent, life-long segregation of mentally ill people.

12. See Appendix A, Compendium of Purposeful State Action for the Segregation and Exclusion of Retarded People in the Fifty States and the District of Columbia [references to App. A hereinafter cited as "A-\_\_\_\_\_"].



State at Large relieved from the heavy economic and moral losses arising by reason of their existence."

1919 Fla. Laws 231, §§ 1, 8; and *as did Utah*, in the same year the predecessor to the Cleburne ordinance was enacted, 1929 Utah Laws 102, ch. 75, §§ 1, 29 (App. A-71.).

The animus of each was everywhere the same. A sampling from Appendix A of the very titles recurrent among the many pamphlets advancing institutional segregation describes vividly that ill-will: *The Menace of the Feeble-Minded in Pennsylvania* (1913); *The Menace of the Feeble-Minded in Connecticut* (1915); *The Burden of Feeble-Mindedness* (1912) (Mass.); *The Feeble-minded, Or, The Hub to Our Wheel of Vice* (1913) (Ohio).

The policy of exclusion of retarded people, implemented through state action, is epitomized by a Mississippi law creating a "Colony for the Feeble-minded" for the segregation of "all cases" deemed "unfit for citizenship."<sup>13</sup> That law, and the others like it, present as starkly as imaginable the essence of an equal protection violation, exclusion of a particular people from the very "citizenship" of the land. Government officials in every state established formal policies in inexorable fashion: Retarded people were "entirely unfit to go into general society,"<sup>14</sup> a "menace to the happiness . . . of the community,"<sup>15</sup> "unfitted for companionship with other children,"<sup>16</sup> a "blight on mankind"<sup>17</sup> whose very "presence"<sup>18</sup> in the community was "detrimental to normal" people,<sup>19</sup> and whose "mingling . . . with society" was "a most baneful evil."<sup>20</sup>

Official policy was to "prevent this class of persons from coming in contact with the populace,"<sup>21</sup> to "purge society"<sup>22</sup> of these

13. A-47 (emphasis provided); see also A-19 (Pa.).

14. A-43 (Wis.); see A-24 (Ind.) ("unfit to be out in the world").

15. A-44 (Ala.).

16. A-74 (Wash.).

17. A-21 (Vt.).

18. A-21 (R.I.).

19. A-63 (Cal.).

20. A-70 (Ore.).

21. A-67 (Colo.).

"anti-social beings,"<sup>23</sup> to "segregate [them] from the world,"<sup>24</sup> so that they "not . . . be returned to society"<sup>25</sup> since "[m]ental defect . . . wounds our citizens a thousand times more than any plague."<sup>26</sup> "Nothing" would better "promot[e] our best citizenship, than to segregate the feeble-minded."<sup>27</sup>

To that end, the enactments of nine state legislatures specified "segregation" in the body of their laws<sup>28</sup> and the official documents of practically each other state and of the United States for the District of Columbia specified the same object.<sup>29</sup>

Institutions, as a matter of law, were houses of "detention"<sup>30</sup> where retarded "inmates" were "kept"<sup>31</sup> and "held"<sup>32</sup> "for life."<sup>33</sup> As the official reports indicate, detention would be "permanent,"<sup>34</sup> in the nature of "an indeterminate sentence"<sup>35</sup> to the "institutional community where he'll always live,"<sup>36</sup> since "a defective child will be a defective adult, and will die a defective. There is not a philosopher's stone to turn the base metals of defect into gold."<sup>37</sup> They could never be let "loose in the world."<sup>38</sup>

22. A-43 (Wis.).

23. A-19, 20 (Pa.).

24. A-23 (Ind.).

25. A-34 (Neb.).

26. A-73 (Utah).

27. A-21-22 (Vt.).

28. A-45 (Fla.); A-29 (Ky.); A-47 (Miss.) ("isolation and segregation"); A-35 (Neb.) ("to segregate them from society"); A-9 (N.H.); A-19 (Pa.); A-38 (S. Dak.); A-57, 59 (Va.); A-74 (Wash.).

29. E.g., A-66 (Cal.); A-67 (Colo.); A-2 (Conn.); A-27 (Kan.); A-23 (Ind.); A-8 (Mass.); A-31 (Mich.); A-10 (N.J.); A-18 (N.Y.); A-49 (N.Car.); A-37 (Ohio); A-50-51 (S.Car.); A-56 (Tex.); A-73 (Utah); A-22 (Vt.); A-43 (Wis.) ("separating them from society"); A-77-78 (U.S.).

30. E.g., A-22 (Ill.); A-69 (Mont.); A-34 (Neb.); A-37 (Ohio); A-71 (Ore.); A-20 (Pa.).

31. A-11 (N.J.).

32. A-62 (Ariz.).

33. A-62 (Cal.); see A-1 (Conn.); A-35 (N. Dak.).

34. A-8 (Mass.); A-33 (Mo.); A-10 (N.J.); A-19 (Pa.); A-56 (Tex.); A-77 (U.S.).

35. A-59 (Va.); see A-67 (Colo.) (to be "kept in an institution indefinitely"); A-71 (Ore.) "indeterminate detention".

36. A-43 (Wis.).

37. A-46 (Ga.).

and it was felt especially important to keep them "away from thickly settled communities,"<sup>38</sup> "remote from the centers of population for reasons that are obvious."<sup>39</sup> Retarded persons simply did not have the "rights and liberties of normal people."<sup>40</sup> The Executive Secretary of the District of Columbia Board of Charity urged a congressional committee to authorize the erection of an institution since retarded people are "not much above the animal."<sup>42</sup> State officials elsewhere also sought to remove retarded people from the realm of humanity, referring to them as "not far removed from the brute."<sup>43</sup> They were not quite persons, but "by-products of unfinished humanity."<sup>44</sup>

Retarded people were segregated for being a "nuisance to the community,"<sup>45</sup> or a "menace to the happiness . . . of others in the community,"<sup>46</sup> or a "menace to society,"<sup>47</sup> or "for the welfare of the community"<sup>48</sup> or "of society,"<sup>49</sup> or so that "the state at large [may be] relieved from the heavy economic and moral losses arising by reason of their existence."<sup>50</sup> It was important to find a "way of getting rid of these kinds of cases."<sup>51</sup>

Official reports labeled retarded people "a parasitic, predatory class,"<sup>52</sup> a "danger to the race,"<sup>53</sup> "a blight and a misfortune both to themselves and to the public,"<sup>54</sup> whose role "in discount-

38. A-67 (Colo.).

39. A-79 (U.S.).

40. A-2 (Conn.).

41. A-41 (S. Dak.).

42. A-80.

43. A-58 (Va.).

44. A-53 (Tex.).

45. A-22 (Ind.).

46. A-44 (Ala.); A-46 (Ga.); A-47 (Miss.); A-51 (Tenn.); A-60-61 (W. Va.).

47. A-68-69 (Idaho); A-43 (Wis.); A-72 (Utah) ("a social menace").

48. A-62 (Ariz.); A-22 (Ill.); A-47 (La.); A-70 (N. Mex.); A-80-81 (U.S.).

49. A-35 (Neb.).

50. A-45 (Fla.); *accord*, A-55-56 (Tex.).

51. A-3 (Conn.); *see* A-68 (Hawaii) ("a place to get the feeble-minded out of the community").

52. A-8 (Mass.); A-21 (Vt.).

53. A-43 (Wis.).

54. A-27 (Kan.).

ing social progress is by far the most potent influence for evil under which society is struggling today."<sup>55</sup>

The states actively inculcated fear of retarded persons, directed their identification and removal from the community, and enlisted assistance of the public to do so. Government officials undertook major outreach efforts.<sup>56</sup> Physicians, teachers, and social workers were required by law in some states to report to the government all persons "believed by them to be feeble minded."<sup>57</sup> Other states made it "one of the special duties of every health officer and of every public health nurse to institute proceedings to secure the proper segregation and custody of feeble-minded persons."<sup>58</sup> Those states with no formal reporting or registration requirement at least officially encouraged health, welfare, and social workers to be "constantly on the lookout"<sup>59</sup> for potential cases to be institutionalized, and authorized a wide variety of public and private persons<sup>60</sup>—or sometimes simply "any reputable citizen"<sup>61</sup>—to institutionalize a person if a parent or relative "either neglect[ed] or refus[ed]" to do so.<sup>62</sup> Washington state legislators dispensed with that procedure and simply made it a criminal offense, punishable by a \$200 fine, for any parents refusing to perform their "duty" to segregate in the state institution their "feeble-minded" son or daughter.<sup>63</sup> Some states even permitted detention temporarily with no procedural rights for those who were "suspected of being feeble-minded or idiotic."<sup>64</sup> Once parents placed their child in an institution, some states required them to "waive all right to remove such inmate there-

55. A-24 (Ind.).

56. *E.g.*, A-62-63, 65-66 (Cal.); A-25 (Ind.); A-36 (Tex.).

57. A-40 (S. Dak.); *see also* A-71 (Ore.).

58. A-29 (Ky.); *accord*, A-52 (Tenn.).

59. A-28 (Kan.).

60. *E.g.*, A-66 (Cal.) ("any peace officer"); A-49 (N. Car.) ("ministers, teachers, or physicians"); A-50 (Okla.) ("trustees of any township"); A-21 (Vt.) (the "selectman of [any] town"); A-75 (Wyo.) (the county prosecutor).

61. A-5 (Del.); A-22 (Ill.); A-46 (La.); A-51 (Tenn.); A-61 (W. Va.).

62. A-47-48 (Miss.); A-51 (Tenn.); A-61 (W. Va.); *see* A-44 (Ala.) ("notwithstanding the family or relatives may object thereto"); A-50 (Okla.).

63. A-74.

64. *E.g.*, A-36 (N. Dak.).



after either permanently or for a limited time."<sup>65</sup> All of these steps, and others, were thought necessary to segregate those "whose parents or guardians are averse to such actions."<sup>66</sup> Government officials made the judgment that "the presence of the unfortunate child in the home"<sup>67</sup> was "more tragic than any known disease,"<sup>68</sup> and a "menace to . . . the family."<sup>69</sup>

The regime of segregation reached to and was reinforced by systematic exclusion from public schooling,<sup>70</sup> forced sterilization,<sup>71</sup> peonage,<sup>72</sup> bans upon marriage and exercise of the franchise,<sup>73</sup> and even reached to the death of "defective" babies.<sup>74</sup>

Where did it all come from? Previously, in the mid-19th century, Dr. Samuel Gridley Howe and others had established residential schools for retarded people, all small, in or near the towns, with the purpose that retarded children should attend, learn, and return after a little while to their homes to live and to work. Howe insisted that the schools should not become custodial and warned against life-long segregation.<sup>75</sup> By the turn into

65. A-30 (Mich.); A-11 (N.J.); accord, A-69 (Mont.); A-36 (N. Dak.).

66. A-66 (Cal.); accord, A-34 (Neb.) (need for retarded people to be "detained in the institution against the desire of the parent").

67. A-21 (R.I.).

68. A-73 (Utah).

69. A-63 (Cal.); A-6 (Md.).

70. The history of exclusion from the schools is noted in *Pennsylvania Ass'n for Retarded Children v. Pennsylvania*, 343 F.Supp. 279, 294-95 (E.D. Pa. 1972); *Board of Education of Hendrick Hudson School District v. Rowley*, 458 U.S. 176, 191 (1982); and committee reports on the Education of All Handicapped Children's Act, e.g., S. REP. NO. 94-168, 94th Cong., 1st sess. 9 (1975).

71. E.g., A-63-64 (Cal.); A-26 (Iowa); A-5 (Me.); A-59-60 (Va.).

72. E.g., A-3, 4 (Conn.); A-81 (D.C.). Indiana required by law that "the labor in constructing" all of the institution's "buildings, improvements, and facilities shall be supplied as far as possible by the persons committed to the institution." A-24.

73. See Brief of Amici AAMD, et al.; Wald, *Basic Personal and Civil Rights in PRESIDENTS COMMITTEE ON MENTAL RETARDATION, THE MENTALLY RETARDED CITIZEN AND THE LAW* 3, 7-9, 25 (M. Kindred, et al., eds. 1976).

74. *Defective Babe Dies As Decried: Physician, Refusing Saving Operation, Defends Course as Wisest for Country's Good, Watches as Imbecile Child's Life Wanes*, N.Y. Times, Nov. 18, 1915, at 1, col. 3.

75. For Howe's position, see pp. A-6-7.

the new century, however, the times had changed. In 1903 Walter Fernald, a Massachusetts official and a leading figure in the Association of Medical Officers of American Institutions for Idiotic and Feeble-Minded Persons, dismissed Howe's view, saying:

"[T]he Doctor wrote before the tide of immigration had set so strongly to our shores. . . . What is to be done with the feeble-minded progeny of the foreign hordes that have settled and are settling among us?"<sup>76</sup>

A solution equal to the severity and the magnitude of the problem was imperative. In 1913-14, at the request of the United States Public Health Service, Henry H. Goddard — the acclaimed author of *The Kallikak Family*<sup>77</sup> — administered Binet's IQ test to the southern and eastern European immigrants arriving in steerage at Ellis Island. "[G]iv[ing] the immigrant the

76. P. TYOR, SEGREGATION OR SURGERY: THE MENTALLY RETARDED IN AMERICA, 1850-1920, at 160 (Diss. Nw. Univ. 1972), published in P. TYOR & L. BELL, CARING FOR THE RETARDED IN AMERICA: A HISTORY (1984). The standard historical works on America's treatment of retarded people include P. TYOR, *supra*; S. B. SARASON & J. DORIS, PSYCHOLOGICAL PROBLEMS IN MENTAL DEFICIENCY, chs. 12-16 (4th rev. ed. 1969), and EDUCATIONAL HANDICAP, PUBLIC POLICY AND SOCIAL HISTORY (1979); see also Appendix D to this Brief.

77. THE KALLIKAK FAMILY (MacMillan, 1912). Asking "What is to be done?" *The Kallikak Family* concludes:

"... For the low-grade idiot, the loathsome unfortunate that may be seen in some of our institutions, some have proposed the lethal chambers. But humanity is steadily tending away from the possibility of that method. . . . We cannot successfully cope . . . until we recognize feeble-mindedness and its hereditary nature, recognize it early, and take care of it.

"[S]egregation through colonization seems in the present state of our knowledge to be the ideal and perfectly satisfactory method."

*Id.* at 101, 116-117. The leading standard historical works describing the pervasive place of eugenics in the era and its decisive role in action against immigrants, blacks and retarded people include M. H. HALLER, EUGENICS: HEREDITARIAN ATTITUDES IN AMERICAN THOUGHT (1963); K. M. LUDMERER, GENETICS AND AMERICAN SOCIETY: A HISTORICAL APPRAISAL (1972); L. KAMIN, THE SCIENCE AND POLITICS OF I.Q. (1974); Kevles, *Annals of Eugenics*, NEW YORKER, Oct. 8, 1984, at 99-115; *id.*, Oct. 15, 1984, at 99-125; *id.*, Oct. 22, 1984, at 92, 93.

benefit of every doubt," he found that 79% of the Italians, 80% of the Hungarians, 83% of the Jews and 87% of the Russians were feeble-minded.<sup>78</sup>

This was — as Kenneth M. Stamppp writes in his historiographical analysis of this early 20th Century era — "a time when xenophobia had become almost a national disease." It was a time "when Negroes and immigrants were being lumped together in the category of unassimilable aliens." During the first decades of the century,

"the new immigrant groups had become the victims of cruel racial stereotypes. Taken collectively it would appear that they were, among other things, innately inferior to the Anglo-Saxons in their intellectual and physical traits, dirty and immoral in their habits, inclined toward criminality, receptive to dangerous political beliefs and shiftless and irresponsible. In due time, those who repeated these stereotypes awoke to the realization that what they were saying was not really very original — that, as a matter of fact, these generalizations were *precisely* the ones southern men had been making about Negroes for years."<sup>79</sup>

And the solution for the now apprehended "common problem" was, in the new decades of a new century, precisely similar: state-imposed segregation alike of "the Negro" and of retarded people.

The animus that supported segregation of "the feeble-minded" bore unmistakable similarity to the animus that evoked Jim Crow. Compare titles like *The Menace of the Fee-*

78. Goddard, *Mental Testing and the Immigrants*, 2 J. DELINQUENCY 243, 249, 252 (1917). Additional "findings" were extensively reported, e.g., N.Y. Times, Jan. 13, 1913, at 10 ("Alien Defectives"); see A-12-16, 64-65.

79. K. M. STAMPP, *The Tragic Legend of Reconstruction*, the introduction in ERA OF RECONSTRUCTION 19-20 (1965) (Stamppp's emphasis).

The standard historical works on the response of the era to immigration, describing its crucial contribution to the adoption of Jim Crow and its identification of new immigrants as so fearfully subhuman as to require state action, include T. J. ARCHDEACON, BECOMING AMERICAN: AN ETHNIC HISTORY 158-172 (1983); J. HIGHAM, STRANGERS IN THE LAND: PATTERNS OF AMERICAN NATIVISM 1860-1925, at 131-175 (1978); O. HANDLIN, THE UPROOTED 247-267 (2d ed. 1973); see also J. S. HALLER, OUTCASTS FROM EVOLUTION: SCIENTIFIC ATTITUDES OF RACIAL INFERIORITY, 1859-1900, at 170-175 (1971).

ble-minded in Connecticut (1915) with such popular southern works advancing Jim Crow as *"The Negro a Beast": Or "In the Image of God"* (1900); *The Negro: A Menace to American Civilization* (1907). They were, alike, "a part of the then current literature of the 'Yellow Peril' school and the flourishing cult of Nordicism."<sup>80</sup>

Champions of life-long segregation for retarded people explicitly invoked the then-exploding prejudice against black people. For example, in 1903, Martin W. Barr, President of the American Association of Medical Officers for Institutions for Idiotic and Feeble-Minded Persons, addressed the virtues of "life-long custodial service" in retardation institutions in these terms:

"[T]hey partake of the industrial and manual training given in the antebellum days on the plantation, which were in fact — as the world is fast acknowledging — training schools for a backward race, many of whom were feeble-minded."<sup>81</sup>

The recitations of the arguments supporting life-long institutional segregation of retarded people matched the recitations on behalf of Jim Crow: "the shibboleths of . . . the Negro's innate inferiority, shiftlessness, and hopeless unfitness for full participation in the white man's civilization"; invocation of "the su-

80. C. V. WOODWARD, THE STRANGE CAREER OF JIM CROW 94 (3d rev. ed. 1974). Other standard historical works on Jim Crow include J. H. FRANKLIN, FROM SLAVERY TO FREEDOM: A HISTORY OF NEGRO AMERICANS (5th ed. 1980); R. KLUGER, SIMPLE JUSTICE (1975); I. A. NEWBY, JIM CROW'S DEFENSE: ANTI-NEGRO THOUGHT IN AMERICA 1900-1930 (1965); G. M. FREDERICKSON, THE BLACK IMAGE IN THE WHITE MIND (1971).

81. Barr, *State Care of the Feeble-minded*, 76 N.Y. MED. J. 1159 (1903). Compare the 1900 address of the President of the Southern Education Association on behalf of Jim Crow, quoted in C. V. WOODWARD, *supra* note 80, at 95.

Champions of Jim Crow invoked the stereotypes of feeble-mindedness against black people. For example, Henry Fairfield Osborn, leading paleontologist and President of the American Museum of Natural History from 1906 to 1933, wrote that the intelligence of "the Negro" rarely exceeded "that of the eleven-year-old youth of the species *Homo sapiens*"; A. B. Hart wrote, "the Negro mind ceases to develop after adolescence." Osborn, *The Evolution of Human Races*, 26 NAT. HIST. 5 (1926); A. B. HART, THE SOUTHERN SOUTH 104 (1910).



preme law of self preservation"; and the necessity of "the stronger and cleverer race, free to impose its will upon new caught, sullen peoples."<sup>82</sup> William Graham Sumners' 1907 *Folkways* was seized upon to establish "the irremedial backwardness of the negro and the futility of efforts to improve him."<sup>83</sup>

Asserted dangerousness was crucial to the arguments for permanent segregation. For Jim Crow, "a sensational press played up and headlined current stories of Negro crime . . . , a daily barrage of Negro atrocity stories."<sup>84</sup> For life-long segregation of retarded people, the fiction of their dangerousness was also systematically invented and perpetuated. In Texas, for example, in 1914, the State Conference on Charities and Corrections was told by one of its leaders:

"The refusal of Texas to make provision for its feeble-minded for the simple reason that from them they fear no personal bodily violence is an increasing menace to the mental and spiritual life of our State, in contrast to which the fancied physical safety is negligible. I have used the phrase fancied physical safety, advisedly, for security from bodily ills is not gained through segregation of the insane and promiscuous freedom of the feeble-minded. . . . Not only are the feeble-minded a menace as regards actual criminal proclivities but they are equally a menace as regards public health."<sup>85</sup>

The Jim Crow movement proceeded in "mounting stages of aggression" until, by 1911 " [i]ts spirit is that of an all-absorbing autocracy of race, an animus of aggrandizement which makes, in the imagination of the white man, an absolute identification of

82. C. V. WOODWARD, *supra* note 80, at 70, 72-73.

83. R. KLUGER, *supra* note 80, at 86.

84. C. V. WOODWARD, *supra* note 80, at 86.

85. PROCEEDINGS (1914), *supra* note 10, at 63. The General Secretary of the National Conference on Charities and Corrections had in 1899 set the National Conference on a campaign to persuade the public that "the feeble-minded" were dangerous. Johnson, *Report of the Committee on Colonies for Segregation of Defectives*, 30 PROC. NATL CONF. CHARITIES & CORRECTIONS 248-49 (1903), quoted in P. TYOR, *supra* note 76, at 184; see also Barr, *The Imbecile and Epileptic Versus the Taxpayer and the Community*, 29 PROC. NATL CONF. CHARITIES & CORRECTIONS 163 (1902).

the stronger race with the very being of the state." <sup>86</sup> As Richard Kluger has written:

"Keeping blacks separate, everyone understood, would prevent contamination of white blood by the defective genes of colored people, whose unfortunate traits stemmed from their tribal origins in densest Africa and were incurably fixed upon the face from generation to generation. . . . [T]heir very blackness bespoke their low and brutish nature. All literature, folklore, and custom of the English-speaking peoples reinforced the notion that the African's tawny hide was a primal stain."<sup>87</sup>

The apotheosis of the demands of racial purity was, as the State of Kentucky represented to this Court in its brief in *Berea College v. Kentucky*, 211 U.S. 45 (1908):

"If the progress, advancement and civilization of the twentieth century is to go forward, then it must be left not only to the unadulterated blood of the Anglo-Saxon-Caucasian race, but to the highest types and geniuses of that race. . . ."<sup>88</sup>

The demands of "racial betterment" required the very most severe measures within their grasp. Solutions beyond segregation were examined but had to be discarded. The Texas pamphlet was illustrative: ". . . euthanasia, neo-malthusianism, and polygamy are either impossible under the protective forces of modern social conditions or are ideas repugnant to present day ideas of religion and humanity." *Segregation* "has appealed to society's feelings of humanity and fair play with greatest force." *Segregation* is "the most feasible, most easily put into force, and least subversive of constitutional prerogative"<sup>89</sup> — a plain statement of the impact on the Era of *Plessy v. Ferguson*, 163 U.S. 537, 544-52 (1896). Without *Plessy*'s permission, no state in contemplation of the Fourteenth Amendment could have dared to impose life-long segregation upon any citizen.

86. C. V. WOODWARD, *supra* note 80, at 108.

87. R. KLUGER, *supra* note 80, at 305.

88. *Id.* at 87.

State-imposed segregation was justified as benign and even beneficial to its victims according to the near constant professions of those who established it. Segregation of "the feeble-minded," the Texas rationale went, consistent with a "deep and abiding charity," "permits all to live under those circumstances best suited to make each useful and happy."<sup>90</sup> As to segregation by race, a Texan wrote, "both races believe that a separate social life is most desirable and most practical."<sup>91</sup> Jim Crow in Texas was not "petty persecution of the Negro, attributed to a desire to humiliate, stigmatise, and degrade him, [it is] the embodiment of enlightened public policy, and is the surest guarantee of a minimum of friction between the races."<sup>92</sup> Separation, President Woodrow Wilson said, was "not humiliating, but a benefit . . . rendering them more safe in their possession of office and less likely to be discriminated against."<sup>93</sup>

The Cleburne ordinance excluding "homes for the . . . feeble-minded" is thus not an isolated enactment but the perpetuation of a pattern of invidious inflictions.<sup>94</sup> Indeed, the legislation from which Cleburne's exclusionary provision is copied — Dallas' ordinance of 1929<sup>95</sup> — was formulated in the era that established the state regime for the life-long segregation of retarded people.

This case will determine whether that regime of segregation will be disestablished and whether a decent respect will be ex-

90. *Id.* at 83.

91. R. E. SMITH, *CHRISTIANITY AND THE RACE PROBLEM* 10 (1922).

92. A. H. STONE, *STUDIES IN THE AMERICAN RACE PROBLEM* 64 (1908).

93. R. KLUGER, *supra* note 80, at 91.

94. Amici had available to them, in the library of the University of Texas at Austin, current zoning ordinances of sixty Texas cities. Of these, the codes of twelve cities explicitly exclude homes for persons with retardation from neighborhoods where comparable dwellings for non-retarded persons are permitted. They are AMARILLO CODE, chs. 26-8, 26-11(43a); BEAUMONT CODE, §42-15(A)(1); CAROLLTON CODE, art. XV(14); COPPERAS COVE CODE, §5-4(m); DUNCANVILLE CODE, art. III(14); EDINBURG CODE, art. IV, §4-2(3); KILLEEN CODE, ch. 9, art. 2, §8-1(f); MIDLAND CODE, §11-1-10(A); NEW BRAUNFELS CODE, §6C.1-6; PORT NECHES CODE, §24-6; SAN ANGELO CODE, §33-2-14(f); SULPHUR SPRINGS CODE, art. 6(a).

95. The ordinances are set out in App. B.

tended to retarded people. Disestablishing that regime requires the full measure of equal protection lest retarded people be again treated as "unfit for citizenship."<sup>96</sup>

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96. 1920 Miss. Laws 288, set out at p. A-47.



## **APPENDIX C**

## APPENDIX C

### COMPENDIUM OF MATERIALS AND STATEMENTS FROM AMICI PEOPLE FIRST AND SPEAKING FOR OURSELVES

#### INTRODUCTION: THE NAMING OF "PEOPLE FIRST" AND "SPEAKING FOR OURSELVES"

*All at once out of the back of the room someone suggested that the name ought to reflect what they were all about. Their name should say who they were and what they wanted. "We are People First," someone said in a loud voice. "PEOPLE FIRST!" [T]he vote was taken and the decision made ....<sup>1</sup>*

*When the time came to give themselves a name, they decided to call themselves "Speaking for Ourselves." Later, member Roland Johnson was asked how they arrived at such a picturesque name. Mr. Johnson screwed his face up into dead seriousness. Then, with the voice of a judge, he said, "Oh, can't you see it? What we call ourselves is what we do." Becoming even more somber, he said, "We simply refused to give ourselves one of those alphabetic names -- like NARC or AAMD or TASH -- and force people to sit on their hands for days trying to figure out what those letters meant."<sup>2</sup>*

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<sup>1</sup> DYBWAD & BERSANI, NEW VOICES: SELF-ADVOCACY BY PEOPLE WITH DISABILITIES 22 (1996)(citation omitted(emphasis in original)).

<sup>2</sup> *Id.* at 27 (emphasis in original).



## TABLE OF CONTENTS

|  |     |
|--|-----|
| A. RIGHTS, RESPONSIBILITIES<br>AND HELPER RESPONSIBILITIES ..... | C-3 |
|--|-----|

|   |     |
|---|-----|
| B. "CLOSE THE DOORS: CAMPAIGN<br>FOR FREEDOM—A NATIONAL PROJECT<br>TO SUPPORT THE CLOSURE OF INSTIUTIONS" ..... | C-4 |
|---|-----|

|   |      |
|---|------|
| C. REPRESENTATIVE RESOLUTIONS<br>IN SUPPORT OF THE CAMPAIGN FOR FREEDOM ..... | C-10 |
|---|------|

|  |      |
|--|------|
| D. BIBLIOGRAPHY OF THE<br>SELF-ADVOCACY MOVEMENT ..... | C-16 |
|--|------|

C-2

## A. RIGHTS, RESPONSIBILITIES, AND HELPER RESPONSIBILITIES

(People First organizations have statements of rights and responsibilities, of which the following is representative.)

D.D. DATELINE

February 1999

PAGE 7

## F72 People First of California Rights and Responsibilities

We are People First. Our disabilities are a normal part of life. As American Citizens, we have the same rights and must meet the same responsibilities as anyone. We're entitled to the support we need to do that.

| Rights   | Responsibilities  | Helper Responsibilities   |
|--|---|---|
| To live like normal people.  | To not harm others or ourselves.                                      | To create a variety of options.   |
| To have the relationships we choose.   | To treat others as equals, with respect.                              | To provide opportunities for meeting different kinds of people                                      |
| To have the medical care we need.  | To take care of our health, and to ask for help if we need it.        | To respectfully offer assistance in accessing necessary healthcare.                                 |
| To learn all we can.   | To use what we learn.   | To teach what we know and introduce people to settings where they can learn.                        |
| To control our lives, take risks, and make choices.                                      | To be responsible for the consequences of our own actions.            | To teach consequences and allow people to learn from them.  |
| To come and go as we want.   | To be dependable and let people know where we are.                    | To avoid making choices for other adults.   |
| To be free and not in state hospitals.   | To accept other places to live, and not act out on other people.      | To create safe, comfortable and stimulating options.  |
| To have wishes and dreams.   | To believe in ourselves, keep control, and not get mad at ourselves.  | To introduce people to the vast array of possibilities and also the idea that dreams can take time. |
| To be respected as equals.   | To act like an equal.   | To work with people.  |
| To have and express our own feelings and opinions – and to be heard and taken seriously. | To find out what's right for us, and speak up in whatever way we can. | To accept that different people have different – and valid – opinions.                              |
| To be free to ask for what we want.  | To ask when we want something from someone.                           | To really listen to what someone is asking for.   |
| To stand up for ourselves to people, agencies and the government.                        | To be strong, face our fears and ask for help when we need it.        | To learn to be better helper/facilitators of self-advocacy.   |
| To live free from abuse.   | To tell if someone is harming us.                                     | To keep our eyes and ears open and act on what we learn.  |
| To work.   | To do the job right.  | To support people in being successful in their work lives.  |
| To have fun.   | To not hurt anyone in the process.                                    | To make teaching fun and having fun a high priority.  |
| To get information from professionals.   | To think about the information we get.                                | To provide information or seek out what we don't know.  |
| To have privacy.   | To ask for a place away from people.                                  | To respect and facilitate people's privacy.   |

C-3

## Close the Doors: Campaign for Freedom Helping People Leave an Institution

### How to help people while they are in the institution:

1. Help people get used to moving a little bit at a time.
2. Get people moral support, training, someone to talk with, and help from casemanagers.

3. People First members can help by:



a. get people to come to a local chapter

b. visiting people in the institution - meet people in institutions before they move, be a friend to people, take them places, i.e. your home, churches, show them what the community looks like



c. start chapters in institutions - help people learn how to speak up for themselves and learn about moving, make visits, talk about living in the community.

d. make presentations to people in the institution about advocacy and independence and living in the community.

### How to help people after they move out of the institution?

1. Visit people in their new places and check on them to be sure they are o.k.
2. Call them on the phone.



3. Help them join a People First Chapter. Take them to a local chapter and help them learn what People First is all about and how they can speak up for themselves and become more independent.

4. People should be able to learn from their own mistakes.

## Close the Doors: Campaign for Freedom Top Ten Arguments You Will Hear *Against* Closing Institutions

1. They won't make it in the community because they have too many disabilities and can't take care of themselves.

If, they have the supports and services in the community, they can move. They can make it. The state should responsible to do this.

2. Institutions should be a choice: people like living in the institutions.

Nobody has had the option to live other places with the supports they really need. How can they more a choice without experience. Would you choose to live there?

3. People will end up on the streets.

We don't want anyone to move until we are sure that the supports and services are in place for them.

4. The people are perpetual children. they only have minds of two year olds.

Since when do we lock up two year olds?

5. Parents and families don't want them to move.

Research shows that families who are against people moving change their minds afterwards because they see the real good positive things that can happen.

6. This is a good institution. everything they need is right there. like doctors and nurses in case of an emergency.

You can get the same things in the community, the community has good medical and other services for people.



7. The community system isn't ready and won't be accountable for what happens.

As more people move, the community system will have more resources to help people. People will have more people in their lives to look out for them.

8. There's no guarantee the money will be there.

People have been living in good community services for many years. The same funds that pay for the institutions can pay for the community.

9. Society isn't ready, they'll be made fun of and won't have friends.

There will be more opportunities for people to make friends because research shows people go more places and do more things.

10. The employees will lose their jobs and it will hurt the community where the institution is.

It's the state's responsibility to plan what will happen to the employees. Experience shows that state employees get other jobs in state agencies.

**The Bottom Line:** This is a human rights and constitutional rights issue. People have the right to live in the community.

## **Close the Doors: Campaign for Freedom Parent Attitudes Toward Closing Institutions**

Many parents who have children living in institutions are happy to see their family members moving out of these places. Others are concerned about them moving to the community. Common questions that they ask include the following: "Will my son or daughter be safe in the community?" "Will they have friends?" "Will I be able to visit them in the community?" "Will they always have a home to live in?"

A lot of professionals asked parents what they thought about their sons and daughters before and after they moved. Two of these professionals (Larson and Lakin, 1991) reviewed 21 studies that looked at parental attitudes and expectations about their children moving out of institutions. From these studies, the following conclusions were made:

- **The vast majority of parents were satisfied (secure, content, and comfortable) with their family member living in an institution.**

Eleven of the studies asked parents questions before their son or daughter moved. 91% said they were somewhat or very satisfied with the institution. Only 21% of the parents supported the idea of having their son or daughter move to the community.

- **The vast majority of parents changed their attitudes about community placement after their family member moved.**

Four studies surveyed parents before and after their family member moved. Only 15% of these parents had a positive reaction about their son or daughter moving before the move. After the move, 62% of the parents expressed a positive opinion about the move to the community.

Before the move, 83% of the parents reported satisfaction with the institution. After the move, 87% were satisfied with the community.

- After experiencing community services, parents viewed the institution less positively than they did when their family member lived there.

Seven studies interviewed parents whose sons or daughters had moved into the community about their satisfaction with the institution, the community, and their opinion of the move. Only 51% said they had a positive reaction about their family member moving to a community home before it happened. This compares with a 83% predischarge rate of satisfaction with the institution and a 15% rate of support for the move. The same parents reported an 88% rate of satisfaction with their children's community living experiences.

- Parents observed improved quality of life and relationships for their family members after the move.

In five studies, more than 65% of the parents reported after the move that their family member was happier, that relationships between their son or daughter and other people improved, that needed services were available, and that staff members in the home were fine. Fewer than 12% reported negative changes in these areas.

## C. REPRESENTATIVE RESOLUTIONS IN SUPPORT OF THE CAMPAIGN FOR FREEDOM





## Speaking For Ourselves

### POSITION STATEMENT ON CLOSING INSTITUTIONS

We believe that all institutions should be closed and abolished. Everybody with all types of disabilities should live in the community.

- People in institutions are getting abused and hurt real bad. People are dying and getting mistreated.
- People in institutions want to be part of the community, be free, have control of their lives, make decisions, vote, have jobs, have a better life.
- People's voices need to be heard and listened to and supported by technology.
- People should have a quality place to live. Quality means:
  - a safe and secure home
  - a place that we can call our own
  - a home where we have the supports we need that we said we wanted
  - be connected with people and be involved in the community
- People should make their own choices and be supported to be in charge of their own lives.
  - where they want to live
  - friends and relationships
  - jobs
  - freedom to come and go
  - who you want to live with
- No one should have the right to put people in institutions at all!!

Developed and approved by the Board of Directors June 1995

One Plymouth Meeting, Suite 630, Plymouth Meeting, Pennsylvania 19462  
Phone (610) 825-4592 FAX (610) 825-4595 TABB 1-800-867-3330  
Received Time Mar. 2. 4:01PM

People First of Alabama  
presented Dr. Ellen Gillespy, Region V Director,  
of the Alabama Department of Mental Health/Retardation  
with the following resolution at the  
"Celebrating Community Living" luncheon.

## Resolution

Whereas, People First of Alabama, an organization of individuals with mental retardation and other developmental disabilities, believes community living is the option of choice for people with disabilities regardless of the severity of their disability,

Whereas, individuals with mental retardation can live independently in the community when given needed supports and services, therefore,

Be It Resolved that People First of Alabama strongly supports the independence of all individuals with mental retardation and other developmental disabilities and further believes that,

People with mental retardation and other developmental disabilities should live in their own homes, apartments, or with their own families.

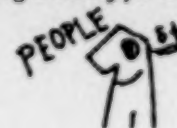
People with mental retardation should be provided opportunities to observe, experience and participate in the diversity of lifestyle options in their communities to assure that individuals have the opportunity to express their true preferences and experience true choice.

People with mental retardation should not live in institutions.

People with mental retardation should be provided supports and services in their community based on their needs.

Be It Further Resolved that People First of Alabama has joined forces with Self Advocates Becoming Empowered (SABE), the national organization of self advocates who are advocating for the closure of institutions in the country by making community living for all a reality through their "Campaign for Freedom."

Be It Further Resolved that given all the statements above, People First of Alabama strongly advocates and encourages the Honorable Fob James, as Governor of The State of Alabama, to issue a mandate to the Department of Mental Health and Mental Retardation to continue its efforts, as initiated by the closure of the Glenn Ireland Developmental Center, by the aggressive development of strategies that make community living a reality for all individuals served by the Department by the year 2000.



Presented by People First of Alabama  
on the 20th day of December, 1996



**ADVOCATES IN ACTION**  
*A Statewide Coalition of Self-Advocacy Groups*

March 2, 1999

To Whom This May Concern,

I am writing this letter on behalf of Advocates in Action. Advocates in Action is Rhode Island's statewide Self-Advocacy organization. We are directed by a board of 16 people who have developmental disabilities.

We are proud to tell you that Rhode Island closed its institution several years ago. We speak for many Rhode Islanders when we tell you that this was a good thing! People should NOT be institutionalized against their will.

I can speak from personal experience. I have cerebral palsy. I was sent to a home after my wife divorced me and didn't want to take care of me any longer. I wasn't able to take care of myself, but I was in good health. I felt like I was in jail in that nursing home! With the help of the state of Rhode Island and United Cerebral Palsy, I am living in my own apartment. I have staff who come in and support me and I use some different types of equipment to live on my own. I have been told that my present support even costs less than the round the hour care I received in the nursing home. It also feels wonderful to be out of that jail!

Today I am writing to you to speak up and help other who would also like to be released. Please don't make people live in an institutions against their will. We are all human beings!! If you have any questions, please call me at 401-944-6149.

Thank you!

Rolf Gjertsen, President  
Advocates in Action

**Advocates in Action**

Box 41528  
Providence, RI  
02904-1528

☎ 401 - 785 - 2965 ☎



**PEOPLE FIRST® OF CALIFORNIA, INC.**  
1223 8<sup>th</sup> Street, Suite 390 - Sacramento, CA 95814  
Phone - (916) 332-6623 - Fax

Revised March 3, 1999

To whom it may concern:

We have heard why it is important to get people out of Developmental Centers (state institutions) and into a good supportive living environment and why others are fighting to keep developmental centers open. With this information we adopted the below policy at our April 1998 Board of Directors meeting.

We, People First of California, Inc., support the closing of the doors to Developmental Centers (State Institutions) in California with the following in mind:

We want people to have the freedom to live outside of Developmental Centers in the community with supported living arrangements.

We want less confinement for people with developmental disabilities, our peers.

We want people to have the chance to make a better life.

We want the state to ensure that the community care system knows what they are doing in regards to people with severe disabilities or medical challenges.

We want the state to provide financial equality to raise the rates for community staff who work with people with developmental disabilities so that better care is provided and better training is ensured.

We hope that you would support us in these efforts to help our peers live an independent and safe life out in the community. Thank you for your support.

Sincerely, *see for CA*  
Carlos Quintong, President

First Adopted by People First of California, Inc. June 13, 1998



## TEXAS ADVOCATES POSITION STATEMENT

### Community Living

Texas Advocates is a statewide organization of people with mental retardation. Our job is to speak for ourselves and other people with mental retardation.

- BECAUSE, Many people in Texas are talking about closing state schools and helping state school residents live in regular neighborhoods and communities;
- AND BECAUSE, We believe that people with mental retardation have a better chance of living full and happy lives if they live with the rest of us in our communities rather than in large institutions;
- AND BECAUSE, It is our job to speak for persons like us about changes that affect our lives;
- AND BECAUSE, It is right and important for us to take a stand on the problem of providing the best kind of services to people with mental retardation.

The membership of the Texas Advocates has agreed to these statements:

"Texas Advocates believe that all persons with mental retardation have the right and should be given the chance to live in their own home communities and neighborhoods."

"Texas Advocates want the state to put together programs in our communities to meet the needs of all Texans with mental retardation."

"We also want the state to help all state school residents move back to their home communities and to slowly phase out and eventually close state schools."

*Adopted by the Texas Advocates Board of Directors, July 19, 1991  
Adopted by the delegates at the Annual Membership Meeting, July 20, 1991*

## People First of Washington

### Our Belief Statement on Closing Institutions



People with all kinds of (dis)ABILITIES have the right to live in our communities ...we have the right to work, live, have fun, make friends, take risks, and learn to speak up for ourselves.

People have the right to make informed choices.

**We believe that no person should be isolated/segregated from our communities.**

That is why we want institutions closed.

We object to anyone controlling anyone else's life. We will strive for quality and equitable services for all people. We will pledge our support and help to those people to find friends, supports, and resources in their new homes.



**D. BIBLIOGRAPHY OF THE SELF-ADVOCACY  
MOVEMENT**

A rich variety of information has been published on self-advocacy. Self Advocates Becoming Empowered has published booklets and materials describing the goals of self advocates published by Self Advocates Becoming Empowered, including: OPEN THE DOORS: THE NUTS AND BOLTS OF BUILDING SUPPORTS FOR EACH OTHER (1996); TAKING PLACE: STANDING UP AND SPEAKING OUT ABOUT LIVING IN THE COMMUNITY (1994). Additionally, volume 8(3) of IMPACT (Institute on Community Integration, Univ. of Minn., Summer 1995) focuses on leadership by people with disabilities.

For historical background and description of self-advocacy, see DYBWAD & BERSANI, EDS., NEW VOICES: SELF-ADVOCACY BY PEOPLE WITH DISABILITIES (1996); M.F. Hayden *et al.*, *Trends and Milestones: Growth in Self-Advocacy Organizations*, 33 MENTAL RETARDATION 342 (1995).



**APPENDIX D**

## APPENDIX D

### BIBLIOGRAPHY AND COMPENDIUM OF EXPERIENCES WITH COMMUNITY INTEGRATION

Amici offer this Bibliography of systemic studies from around the country as well as this Compendium of experiences of people with disabilities, that describe the integration for people with disabilities over the past three decades. These materials may serve as a guide to the experiences of thousands of people with disabilities who, like L.C. and EW, have left large, segregated institutions and have moved into homes in the community. The experience of integration, as examined and described by systemic studies and as told by people with disabilities themselves, may supply a context for Respondent's claims.

#### I. BIBLIOGRAPHY OF SYSTEMATIC STUDIES OF COMMUNITY INTEGRATION

##### LONGITUDINAL STUDIES OF PEOPLE WHO HAVE LEFT INSTITUTIONS AND ARE INTEGRATED INTO THE COMMUNITY

Several longitudinal studies have documented the success of moving people out of institutions and integrating them into the community. Commissioned by courts and state governments, these studies compared the quality of life of the same people both when they lived in the institution and after they were integrated into the community. The studies overwhelmingly show that persons with developmental disabilities tend to live more fulfilling lives when integrated into society, at a lower cost to the state and improved treatment and habilitation.

The studies include: M.F. Hayden *et al.*, *A Matched, Comparative Study of the Recreation Integration of Adults with Mental Retardation who Moved into the Community and those who Remained at the Institution*, THERAPEUTIC RECREATION J.



41 (1st Quarter 1996)(finding that persons who left Minnesota institution became more self-sufficient and independent than those who stayed at institution); M.F. HAYDEN ET AL., DEINSTITUTIONALIZATION AND COMMUNITY INTEGRATION OF ADULTS WITH MENTAL RETARDATION: SUMMARY AND COMPARISON OF THE BASELINE AND ONE-YEAR FOLLOW-UP RESIDENTIAL DATA FOR THE MINNESOTA LONGITUDINAL STUDY (1995); JAMES W. CONROY, THE HISSOM OUTCOME STUDY: A REPORT ON SIX YEARS OF MOVEMENT INTO SUPPORTED LIVING (1995)(commissioned by Okla. Dept. of Human Servs. and U.S. District Court, No. Dist. Okla.)(study of persons leaving Oklahoma institution into homes in the community); CONROY & SEIDERS, 1993 REPORT ON THE WELL-BEING OF FORMER RESIDENTS OF JOHNSTONE (1994)(commissioned by New Jersey Developmental Disabilities Council)(tracking former residents for New Jersey institution who moved to community); CONROY & FEINSTEIN, 1990 RESULTS OF THE CARC v. THORNE LONGITUDINAL STUDY (1991)(commissioned by Connecticut Dept. of Mental Retardation)(tracking former residents of Mansfield Training School in Connecticut); VALERIE J. BRADLEY ET AL., COMMUNITY OPTIONS: THE NEW HAMPSHIRE CHOICE (1986)(commissioned by New Hampshire Developmental Disabilities Council)(tracked former residents of New Hampshire's Laconia State School); JAMES W. CONROY ET AL., THE PENNHURST LONGITUDINAL STUDY: A COMBINED REPORT OF FIVE YEARS OF RESEARCH AND ANALYSIS (1985)(joint endeavor by U.S. Dept. of Health & Human Servs. and Temple Univ. Developmental Disabilities Center)(in-depth review of the residents of Pennsylvania's Pennhurst State School, following residents from the institution and into new homes in the community).

For meta-studies of the longitudinal reviews, see Larson & Lakin, *Deinstitutionalization of Persons with Mental Retardation: Behavioral Outcomes*, 14 J. ASS'N. FOR PERSONS WITH SEVERE HANDICAPS 324 (1989)(analyzing 18 studies of outcomes of persons moving from institutions to communities);

Larson & Lakin, *Parent Attitudes About Residential Placement Before and After Institutionalization: A Research Synthesis*, 16 J. ASS'N. FOR PERSONS WITH SEVERE HANDICAPS 25 (1991)(analyzing 27 studies); Chen et al., *Personal Competencies and Community Participation in Small Community Residential Programs: A Multiple Discriminant Analysis*, 98 AM. J. MENTAL RETARDATION 390 (1993).

#### OTHER SYSTEMATIC STUDIES OF COMMUNITY INTEGRATION

A recent follow-up study in Georgia of River's Crossing, the first Georgia institution to close, showed the former residents are much better off in terms of quality of life, independence, and educational development since becoming integrated into the community. INSTITUTE ON HUMAN DEVELOPMENT AND DISABILITY, UNIV. OF GEORGIA, RIVER'S CROSSING: TRANSITION FROM INSTITUTION TO THE COMMUNITY (1999).

Other studies from around the country have shown that people with disabilities experience substantially better integrated and more typical life experiences when moving to the community. M.F. Hayden et al., *Social and Leisure Integration of People with Mental Retardation in Foster Homes and Small Group Homes*, EDUC. & TRAINING IN MENTAL RETARDATION 187, 188 (Sept. 1992); see e.g. STEVEN J. TAYLOR ET AL., EDS., THE VARIETY OF COMMUNITY EXPERIENCE: QUALITATIVE STUDIES OF FAMILY AND COMMUNITY LIFE (1995) D. Felce et al., *A Eco-Behavioral Analysis of Small Community-Based Houses and Traditionally Large Hospitals for Severely and Profoundly Mentally Handicapped Adults*, 7 APP. RESEARCH IN MENTAL RETARDATION 393 (1986); B. HILL ET AL., CENTER FOR RESIDENTIAL AND COMMUNITY SERVICES, UNIV. OF MINN., LIVING IN THE COMMUNITY: A COMPARATIVE STUDY OF FOSTER HOMES AND SMALL GROUP HOMES FOR PEOPLE WITH MENTAL RETARDATION (1989); R. HORNER ET AL., OREGON DEVELOPMENTAL DISABILITIES OFFICE, AN ACTIVITY BASED ANALYSIS OF DEINSTITUTIONALIZATION: THE EFFECTS OF

COMMUNITY REENTRY ON THE LIVES OF RESIDENTS LEAVING OREGON'S FAIRVIEW TRAINING CENTER (1988); Frohboese & Sales, *Parental Opposition to Deinstitutionalization: A Challenge in Need of Attention and Resolution*, 4 LAW & HUMAN BEHAVIOR 1 (1980).

## STUDIES OF INDIVIDUAL COMMUNITY PROVIDERS

TAYLOR ET AL., LIFE IN THE COMMUNITY: CASE STUDIES OF ORGANIZATIONS SUPPORTING PEOPLE WITH DISABILITIES (1991) highlights organizations around the country that have successfully integrated people with disabilities into society. Two studies favorably evaluated the results of Monadnock Developmental Services, a New Hampshire community program where people with disabilities administer the services they also receive. CONROY & YUSKAUSKAS, INDEPENDENT EVAL. OF THE MONADNOCK SELF DETERMINATION PROJECT (1996)(commissioned by Robert Wood Johnson Foundation); YUSKAUSKAS, CONROY & ELKS, LIVE FREE OR DIE: A QUALITATIVE ANALYSIS OF SYSTEMS CHANGE IN THE MONADNOCK SELF DETERMINATION PROJECT (1997). Another study reviewed Monadnock's success in finding jobs in New Hampshire's community. PAT ROGAN, SYRACUSE UNIV., TOWARD INTEGRATED EMPLOYMENT FOR ALL (1993).

## II. EXPERIENCES OF PERSONS WITH DISABILITIES, IN THEIR OWN WORDS

### ILLINOIS

*Tia Nelis--Naperville, IL*

How can you have much privacy when you live on a campus with 100 or more people, in a unit with 10-15 people, and share a bedroom with at least one or two roommates? Struggling college students may need to live under such conditions temporarily, but not a 32-year old woman with a job. Institutions provide little privacy.

When I visit the institution the staff think I'm another "client", so I get to see the real story. I see shower rooms with the doors open and curtains pulled back. I see staff opening the doors to people's bedrooms without knocking and walking inside. I see people carrying all their valuables with them -- "hoarding behavior" I think it's called by professionals; the truth is that people are afraid their valuables will be stolen when they leave their rooms. No free access to phones. No privacy when caring for personal matters, sleeping, entertaining that special someone, or just plain wanting to be alone. ...

Living "on the outside" as my friends who live in institutions call it, you decide how much privacy you want. If you like people around all the time, you may choose to live with five or six others. If you don't like noise, then you live with a quiet person. Your phone conversations are private because it's your phone. Your mail is private because you get it from your own mailbox. When people walk into your home, it's because you have invited them. It is your home and you make up the rules. It's called "choice."<sup>1</sup>

*Duane--Addison, IL*

I got my own apartment on May 8th, 1992. It was like coming into heaven. Where I'm living now is really where I want to be ... For 32 years I said I wanted out of the institution. I was so angry and used to cry. I was feeling like an animal--all in one room. They shoved me off like an old shoe. We weren't protected or safe ... I feel more safe in the community. I feel like a person. If I was not in the institution I could of had an education. I could have made my own real friends. Now I got freedom. I would like to help other people have what I have. The providers need help. I would like to tell them I got more

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<sup>1</sup> Tia Nelis, *The Realities of Institutions*, INSTITUTE ON COMMUNITY INTEGRATION, UNIV. OF MINN.: IMPACT, Vol. 9(1), 1 & 27. (Winter 1995/96). Ms. Nelis is the President of *amicus* Self-Advocates Becoming Empowered.



in one year living on my own than 32 years in the institution.<sup>2</sup>

## MASSACHUSETTS

*Russell Daniels--Belchertown, MA*

I was 12 years old when I was sent to a state school. When I left there I was 28 years old ... I wasn't allowed to see my family the first day. They give you a week without seeing them. After a while they start letting you have visitors. In those days they let you go out for the day but when you came back you would be searched. You couldn't have money, watches, rings, or anything. They'd take everything away because that was the rules and regulations.

I'm really proud to be out and I never want to go back to any institution at all ... I have friends that I visit in the institution. They tell me they want to leave because they saw me leaving ... There was one person who didn't want to leave because he didn't figure he would get the care. I said, "Don't worry about that. You will get the care like everybody else." So, they didn't think he would make it, but he did. He got out, and he made it. I saw him the day I left to come here. He said, "Well, wherever you go, you make sure that you bring it up that I made it."<sup>3</sup>

*Robert Cutler--Arlington, MA*

I will type about Fernald [State School, an institution in Waltham, Massachusetts] ... My crime was that no one really understood autism, allergies and sadness in my heart. ... Food was lousy and I had no opportunities to make choices about what I wanted to do on a daily basis. ...

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<sup>2</sup> ENOUGH IS ENOUGH: THE STORY OF PEOPLE FIRST OF ILLINOIS.

<sup>3</sup> *Inside and Out: Former Residents Reflect on Their Lives*, INSTITUTE ON COMMUNITY INTEGRATION, UNIV. OF MINN.: IMPACT, Vol. 9(1), 10-11 (Winter 1995/96).

I finally have a home I share with friends of my choosing. I am now independent and wishes do come true. [I have a] house and now a dog. If this can happen to one of the so called difficult cases in Massachusetts, it should happen for others in the system. ...

Give my friends something you take for granted. Freedom to choose where I live and the right to communicate. But the most important thing, the right to be listened to.<sup>4</sup>

## NEW YORK

*Michael Joseph Kennedy--Syracuse, NY*

I am 28 years old and I have cerebral palsy. I am one of four children. Because no services were available to assist my family and me, I was forced to spend 15 years of my life in state institutions. ...

I started living in the West Haverstraw Nursing Home when I was about 3 years old. I did not like it there because of the treatment the residents received. We were not treated with the respect due to any human being. ... Later I was moved to the Rome Developmental Center in New York State where I received much of the same treatment as at West Haverstraw. I later moved to the Syracuse Developmental Center where I lived from 1979 to 1982. Residents were not respected. We were not given choices or freedom. Some people were abused, although it was better than at Rome.

In 1982, I heard about supported apartments being run here in Syracuse by United Cerebral Palsy, now known as ENABLE. The apartment program was just getting started and I wanted to be a part of it ... I had wanted to get out of the institution for years and I finally saw my opportunity. In August 1982 I

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<sup>4</sup> Mr. Cutler is a member of the Board of Directors of *amicus* the Autism National Committee.

moved into the apartment. I had three roommates who also had disabilities. It was a great improvement over Syracuse Developmental Center. Now I was living with three other people instead of 20, the number of people I roomed with at SDC. But what I liked most was that it was in the community. I could be seen as belonging to the community, and I could experience being around people without disabilities.<sup>5</sup>

## OKLAHOMA

*Roxanne*

Just couldn't hardly stand it [the institution] at all. Just couldn't, from everything that was going on. Breaking everything, stealing ...[The institution] is all locked up now. Shut down and locked. Yeah, I'm glad about that anyway. I really am. I think they [people living in institutions] are going to need to find group homes and anything. So they can get out on their own.

I like everything we're doing down there at home. Get to decide what I'm doing. Going down to the store. Well, would have to go down to the store with the staff. I would have to help them write the menu out with what to get ...

The most thing I'm real glad about now is that I'm going back to school so I'm getting my G.E.D. Well, if I get the diploma, I'll leave it there in the bedroom. But I'll probably hang it up on the wall. Probably. Yeah ...<sup>6</sup>

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<sup>5</sup> Michael Joseph Kennedy, *Out of My Old Life and Into My New One*, CENTER ON HUMAN POLICY, SYRACUSE UNIV., COMMUNITY LIVING FOR ADULTS 3 (Nov. 1989). See e.g. Michael Joseph Kennedy, *Turning the Pages of Life*, in HOUSING, SUPPORT AND COMMUNITY: CHOICES AND STRATEGIES FOR ADULTS WITH DISABILITIES 205-16 (1993).

<sup>6</sup> COLLEGE OF EDUC. & HUMAN DEVELOPMENT, UNIV. OF MINN., LIVING IN THE FREEDOM WORLD: PERSONAL STORIES OF LIVING IN THE COMMUNITY BY PEOPLE WHO ONCE LIVED IN OKLAHOMA'S INSTITUTIONS

*Leon*

I was about 8 years old when I went to [the institution] ... When I was at [the institution], it was very, very depressing. It was not very nice because I was scared. I was really scared. I didn't know what to do. I mean I ain't scared anymore ... I didn't like it in the institution. Didn't have no privacy ... [School was] not like real school. I wanted to have friends around me. ... I was in a room with umpteen beds or more. I didn't have nothing. I didn't have a thing to show. It was bad. I was scared to death. I didn't want to be there. ...

I have a good life now. Make my own coffee ... I live by myself now, and I have my own apartment. I feel good about it because I'm happy living out here. I really like it. I can do anything I want and I prefer doing anything I want to, yeah. ...

I feel real good about myself. When I was in the institution, I was shy. I like where I am now. I like myself. I'm better off now. I'm more happy now. I'm a regular person...<sup>7</sup>

## PENNSYLVANIA

*Frank Sergi--Plymouth Meeting, PA*

I lived in Don Guanella in Delaware County and later Woodhaven Center for 14 years. In October 1996, I moved to the community and now live in Plymouth Meeting. I want to help get all my friends who still live at Woodhaven Center out so they can live in the community like I do. I want them to have a nice home like I have. I think no one should have to live in an institution.<sup>8</sup>

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(1997). The author is the secretary of *amicus* People First of Oklahoma.

<sup>7</sup> *Id.* The author is a member of *amicus* People First of Oklahoma.

<sup>8</sup> *Speaking for Ourselves Members Testify at State Hearings*, SPEAKING FOR OURSELVES 3 (Winter 1997).



*Octavia Green--Philadelphia, PA*

One of my concerns is the people in institutions are getting abused. They don't have the choices like you and I do. People in institutions want choices like you and I do to live out in the community. It cost a lot and if we spent our dollars in the right way we could have the money to get people out of the institutions. The old school doesn't work anymore. With support and help people can live in the community.<sup>9</sup>

*Jean Searle--Philadelphia, PA*

I am now working for [amicus] Vision for Equality & my title is community satisfaction specialist. I started this job in November of last year. I also work for the Disabilities Law Project. [W]hat I do there is answering the telephone and a lot of other things. I moved up to the institution on January 3, 1975 for about 7 1/2 yr. I moved out of the institution in 1984. I just love living in the community and being around new and old people.

#### **RHODE ISLAND**

*Rolf Gjertsen--Providence, RI*

I felt like I was in jail in that nursing home! With the help of the state of Rhode Island<sup>10</sup> and United Cerebral Palsy, I am living in my own apartment. I have staff who come in and support me and I use some different types of equipment to live on my own. I have been told that my present support even costs less than round the hour care I received in the nursing home. It also feels wonderful to be out of that jail!<sup>11</sup>

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<sup>9</sup> *Id.* at 7. Ms. Green is Chairperson of the Board of *amicus* Speaking for Ourselves.

<sup>10</sup> Rhode Island is one of four states that has closed its institutions for people with developmental disabilities.

<sup>11</sup> Mr. Gjertson is the President of *amicus* Advocates in Action of Rhode Island.

#### **SOUTH DAKOTA**

*Mark Samis--Pierre, SD*

I was 15 years old when I went into the institution and I lived there for 12 years. ...

I had no rights. I could not speak up for my rights. If I did, the supervisor or attendants would work me over, flatten me out or things like that. I had no privacy. I could not go to a room to cool down when felt sad about something or didn't want to be bugged, things like that. And I could not sit outside and visit friends of mine who lived on other wards. I could not sit on the merry-go-round, swing set, what have you, to visit with my friends. ...

Now, in the past few years my life has all turned around. Nothing but great things have happened to me since leaving the institution. Maybe it took awhile. Like they say, patience is always rewarded. So I'm very proud of what I do now. I'm hoping to see these institutions all over the United States close and I don't care what they do with them once they get them closed.<sup>12</sup>

#### **UTAH**

*From a People First Member, who is also blind:*

I lived at the Utah State Training School for about 8 or 9 years. I thought it was pretty poor because the food was poor ... They would lock people up like in a jail room, sleeping on an old hard floor, just having a diaper on. ...

I won the Bill Sackter award from The Arc [Association for Retarded Citizens] of Utah and a couple other ones. I was a

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<sup>12</sup> *Inside and Out* at 11.

board member of The Arc of Salt Lake and The Arc of Utah. I am a member of People 1st and a Steering Committee member of Self-Advocates Becoming Empowered.

I have been married for 4 years in June. My wife and I both are legally blind but live in our own apartment. We like to eat out on Friday and Saturday nights. We like to go to different places taking the bus.

#### VERMONT

##### *David Ryan Mansfield--Montpelier, VT*

I went to the Brandon State School at the ages of three to ten years. Because I was classified as being mentally retarded by the Doctors ... In Brandon I didn't have any say about what I did with my life[.] [I]t was all done for me as far as choice being made for. I had no choice about the way I was cared for in Brandon.

I now live out in the community where I can be on my own and I can access down Town Montpelier, and I have took some computer classes to get trained for a job. And I bought my own van for getting back and forth in the community.

##### *Susan Aichroth--Shelburne, VT*

When I was a child I could not go to real classes. I didn't know anything. I was in sheltered workshops. My parents needed a break and sent me to Brandon Training School. For three years I was like a prisoner there, with no key. It was like I had a chain on my leg. I hated it. I couldn't go anywhere outside. One day my parents came and took me out.

My life is different now. I have an apartment with my own key. I have a job that pays me \$15.50 an hour. I have my office at home with a computer and email. I have a pager. I have all these families--my job family, my apartment family, my parents, my community family and everything. My life is just great. No

one knew what I could do. They do now!<sup>13</sup>

#### ARTICLES AND MATERIALS CONTAINING EXPERIENCES OF PEOPLE WITH DISABILITIES WITH COMMUNITY INTEGRATION

Numerous articles and publications have compiled the experiences of people with disabilities when they leave institutions and move to the community. In Georgia, the Program on Human Development and Disability at the University of Georgia published *BUILDING NEW LIVES IN THE COMMUNITY* (1997), a collection of individual experiences of people with disabilities who left Georgia's River's Crossing institution when in 1996 it became the first Georgia institution to close. River's Crossing became an institution as late as 1980, when Georgia converted the former special school into an institution based on the 19th Century custodial model.

The University of Minnesota's College of Education and Human Development, *LIVING IN THE FREEDOM WORLD: PERSONAL STORIES OF LIVING IN THE COMMUNITY BY PEOPLE WHO ONCE LIVED IN OKLAHOMA'S INSTITUTIONS*, interviewed people with disabilities who had left Oklahoma's Hissom Memorial Center and moved to the community. The interviewees describe in detail the positive experiences they have had since leaving Hissom. The University of Minnesota's Institute on Community Integration publishes *IMPACT*, a periodical that tracks the experiences of people with disabilities in the community and publishes articles by people with disabilities on community and institutional living.

*Stories from the Belly of the Beast: Testimony from Survivors of Institutionalization* (Sept. 23, 1996) is a joint publication of Self Advocates Becoming Empowered and the University of

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<sup>13</sup> Mr. Mansfield and Ms. Aichroth are members of *amicus* People First of Vermont.



Minnesota's Research and Training Center on Community Living. The article compiles statements from former institution residents from 22 institutions around the country, and includes former residents' views on institutionalization and segregation as well as the importance of community integration.

## **APPENDIX E**



## APPENDIX E

### COMPENDIUM OF LEGISLATIVE HEARINGS AND OFFICIAL REPORTS UPON WHICH THE CONGRESS RELIED IN DETERMINING THE NATURE AND EXTENT OF DISCRIMINATION

Congress drew upon both extensive legislative hearings and certain official reports and surveys to determine the "nature and extent of discrimination on the basis of disability." H.R. Rep. 101-485(II), IV, 1990 U.S.S.C.A.N. at 310. While Congress' address of unnecessary segregation in floor debates and Committee reports is extensively before this Court in the briefs of Respondents and supporting Amici, the legislative hearings and earlier reports and surveys have been less plumbed. They, too, in stark contrast to Petitioner's claim of a "reverberating silence", Br. at 30, are clear that the unnecessary, historical removal of people with mental retardation from society and their warehousing in large, inhumane institutions was before the Congress and identified as the most aggravating of the forms of discrimination against people with disabilities. This Appendix sets forth some of the statements from the hearings and official reports documenting this discrimination.

#### I. BACKGROUND ON ENACTMENT OF THE ACT

What would become the Americans with Disabilities Act of 1990 began as a proposal of the National Council on Disability. Appointed by President Reagan, the Council in February 1986 submitted to President Reagan and Congress its landmark report, *Toward Independence*, recommending passage of a comprehensive civil rights statute for people with disabilities. At the request of Congress, the Council followed up on its report by directing staff counsel Robert Burgdorf to draft a proposed Americans with Disabilities Act. On November 16, 1987, the Council unanimously adopted a revised version of Burgdorf's bill and in January 1988 submitted it to Congress in

its second report, *On The Threshold of Independence*. Lowell P. Weicker, Jr., Historical Background of the Americans with Disabilities Act, 64 TEMPLE L. REV. 387, 390 (1991).

The Council requested Senator Lowell Weicker (R-Conn.) and Representative Tony Coelho (D-Cal.) sponsor the proposed Act in Congress. With thirteen Senate co-sponsors, Senator Weicker introduced the ADA in the Senate on April 28, 1988. With 33 cosponsors, Representative Coelho introduced the proposed Act in the House of Representatives the next day. Congress held a joint hearing on September 27, 1988, but could not complete deliberation on the bill before the end of the 100th Congress. *Id.* at 391.

In the 101st Congress, Senator Tom Harkin (D-Ia.) became the Act's sponsor and floor manager upon Senator Weicker's request. With 33 co-sponsors, Senator Harkin introduced the revised Act on May 9, 1989. *Id.* The House held a series of eleven public hearings and the Senate three. Hundreds of witnesses testified, including the authors of the bill and regulations, people with disabilities who had been institutionalized and unnecessarily segregated, state mental health and mental retardation officials, and providers of community services for people with disabilities.

## II. STATEMENTS OF WITNESSES AT CONGRESSIONAL HEARINGS

### STATEMENTS AND TESTIMONY OF THE ACT'S SPONSORS AND AUTHORS

At Congress' Joint Hearing on September 27, 1988, sponsoring Representative Coelho issued the following statement concerning institutionalization:

It is barriers and discrimination that have caused an "out of sight, out of mind" situation with disabled people.

When housing is inaccessible and unavailable, the disabled have to stay at home, under the care of their families, or live in nursing homes and other institutions, rather than establishing and controlling their own households next door to you and me. When regular transportation is inaccessible, and transit services for the disabled are segregated, you won't see them on your bus or commuter train. When prejudice dictates that the handicapped can be productively employed only in separate sheltered workshops, you won't see too many of them in your workplace. ... Disabled people are sometimes impatient, and sometimes angry, but for good reason: they are fed up with discrimination and exclusion, tired of denial, and eager to seize the challenges and opportunities as quickly as the rest of us. ... We must stop the cycle of separateness which hides people with disabilities, and creates prejudice, which creates more separateness.

Americans with Disabilities Act of 1988, Hearings Before the Subcomm. on the Handicapped, Senate Labor and Human Resources Comm., and the Subcomm. on Select Educ., House Educ. and Labor Comm., 100th Cong., 2nd Sess. 15 (1988) ("Joint Hearing").

Before the Senate Committee on Labor and Human Resources, Senator Weicker testified:

For years, this country has maintained a public policy of protectionism toward people with disabilities. We have created monoliths of isolated care in institutions and in segregated educational settings. It is that isolation and segregation that has become the basis of the discrimination faced by many disabled people today. Separate is not equal. It was not for black; it is not for disabled.



It is true that, over the past 16 years, we have begun to alter the direction of public policy. With the enactment of Section 504 of the Rehabilitation Act of 1973, Congress said that no longer will Federal funds support or assist discrimination, and last year we reaffirmed that commitment in the Civil Rights Restoration Act. In 1975, with the passage of Public Law 94-142, we said that children with disabilities have a right to a public education, and that no longer would we allow such children to be educated outside of the mainstream of our society. That directive was expanded in 1986 by Public Law 99-457. Most recently, in the Fair Housing Amendments of 1988, we said that no longer will we build multifamily housing that does not allow Americans inside.

The legislation before this committee today completes the work begun in 1973 to secure the rights of Americans with disabilities.

Americans with Disabilities Act of 1989: Hearings on S. 933 Before the Comm. on Labor and Human Resources and the Subcomm. on the Handicapped, 101st Cong., 1st Sess. 215 (1989) ("Senate Labor & Human Resources Hearing"). In response to Senator Weicker's statement, sponsoring Senator Harkin described the experiences of the Piper family in his home state of Iowa whose son, Danny, had Down Syndrome:

You talk about costs. His mother and father estimated that had they followed their doctor's advice and institutionalized Danny when he was very young, he would still be in the institution today. Today it costs about \$200 a day for a kid like that to be in an institution. If he lived in that institution for all his life, let us say up to age 64, that cost would be \$4,745,000 just for the cost of institutionalization. But Danny is not going to be institutionalized. He is going to go out and

work; he is going to make money; he is going to take care of himself. So when you look at cost, you got to look at the cost to all of society. We know it is going to save us billions of dollars.

Senate Labor and Human Resources Hearing at 218.

Attorney General Richard Thornburgh, who later promulgated the ADA regulation requiring that services under Title II be provided in the most integrated setting, told the House Judiciary Committee, "Despite the best efforts of all levels of government and the private sector, and the tireless efforts of concerned citizens and advocates everywhere, many persons with disabilities in this Nation still lead their lives in an intolerable state of isolation and dependence." Americans with Disabilities Act of 1989: Hearings on H.R. 2273 Before the Subcomm. on Civil and Constitutional Rights of the Judiciary Comm., 101st Cong., 1st Sess. 191 (1989) ("House Judiciary Hearing"). The definitive Senate report relied upon Mr. Thornburgh's statement. S. Rep. 101-116 at (Aug. 30, 1989)(quoting same).

At the same hearing, James Brady quoted President Bush as stating in June 1988 that "[a]lthough handicapped children and adults have made many gains in the last decade, the stark fact remains that unnecessary segregation and exclusion of handicapped people continues, and as a result disabled adults and families with disabled children suffer from stress, depression and isolation." Mr. Brady said President Bush called for "programs and policies that promote independence, freedom of choice and productive involvement in the mainstream. That means, in other words, meaningful access to all aspects of society." Id. at 43.

Justin Dart, an original member of the National Council on Disability and considered the father of the ADA, told the House Education and Labor Committee:

America cannot afford either the moral or economic costs of maintaining ever increasing millions of its potentially productive citizens in unjust and unwanted dependency. Investments in the rights and productive independence of all people with disabilities have proven to be immensely profitable to every citizen and to the nation as a whole.

Oversight Hearing on H.R. 4498, Americans with Disabilities Act of 1988, Hearings Before the Subcomm. on Select Educ., House Educ. and Labor Comm., 100th Cong., 2nd Sess. 10 (1988) ("House Oversight Hearing").

#### TESTIMONY OF PERSONS WITH DISABILITIES

From around the country, many persons with disabilities testified and submitted statements to Congress at the hearings. In a hearing held in Boston, the House Education and Labor Committee received the diaries of numerous people with disabilities who testified about the value of freedom and independence as opposed to institutionalization. In her diary, Mary Low Wilcox of Jewett City, Connecticut, wrote, "Living in a convalescent home has caused me to feel useless, hopeless and they demean means. So I have become a passive person, and running scared." House Oversight Hearing at 34.

Cindy Miller of Boston, who relied on personal attendant care services to live in the community, stated:

I live in constant fear that the economic argument subsidizing personal care assistants will be lost and I will be institutionalized. Because independent living is not a right to freedom for Americans with disabilities, this is a realistic fear. But it will not be my choice. As a rehabilitation counselor, I have seen these institutions. The smell of human waste and detergent has stuck in my throat. I have looked into the vegetative eyes of its

inmates and the sterile environments. I have heard of the premature death rates and prevalence of pneumonia, literally allowing them to rot in their beds.

Id. at 161-172. In another hearing, Janna Slisher, an Indianapolis law clerk with quadriplegia, stated:

The majority of persons with disabilities do not relish the thought of sitting day after day in a bedroom or nursing home. The expense of maintaining nursing care for the disabled may be drastically reduced by implementing job training and opening access to employment for the Americans with Disabilities Act.

Americans with Disabilities Act of 1989, Hearing on H.R. 2273 Before the House Subcomm. on Select Educ. of the Educ. and Labor Comm., 101st Cong., 1st. Sess. 10 (1989) ("House Educ. & Labor Hearing").

#### TESTIMONY OF DISABILITY ORGANIZATION REPRESENTATIVES

Members of major disability organizations testified to Congress about the discrimination against and unnecessary segregation of people with disabilities in institutions and nursing homes. In his statement to the Judiciary Committee, James Ellis, the President of the American Association on Mental Retardation, wrote:

People with disabilities have been subjected to invidious discrimination throughout history. In the case of individuals who have mental retardation, this history of discrimination has been described by five members of the Supreme Court of the United States as "grotesque." City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 454, 461 (1985). This discrimination has been pervasive and has reached almost every aspect of the lives of people with disabilities and has denied them the



most basic and fundamental rights of American citizenship.

House Judiciary Hearing at 418.

Eric Griffen, a Vice President of the National Council on Independent Living, testified, "[F]orced segregation and dependency of millions of individuals with disabilities in this country constitutes a gross violation of their constitutional and basic human rights and an increasingly unaffordable drain on public and private budgets and a significant failure of the Great American Promise of liberty and justice for all." House Oversight Hearing at 31.

Marcie Roth of the Connecticut Association for Retarded Citizens and the Connecticut Independent Living Council, described one person's experience with segregation:

Four days ago, Joe was placed in a nursing home 1 hour away from his friends and family. He did not choose this location. It was the first available bed. And he was given less than 24 hours [sic] notice of the impending move. This is the third time this has happened. ... In the new nursing home, he is unable to have his own telephone. He cannot have cable TV, either. He is again rooming with a man who is in his nineties and is dying [Joe was 23 years old]. ... But if there was housing, access to a good job, transportation and quality services available before last April, maybe he would be here today or maybe he would be back at work, today.

House Oversight Hearing at 81. See e.g. *id.* at 62 (statement of Bill Knight, Chairman of the Greater Waterbury [Connecticut] Consumer Action Forum)("[A] segregated society is created due to institutionalization.").

## TESTIMONY AND STATEMENTS OF STATE OFFICIALS

State officials from around the country told Congress about the States' success in integrating people with mental disabilities into the community. Ed Preneta, the Director of the Connecticut Developmental Disabilities Office, testified:

The next powerful movement is the rising of people with mental retardation locked up in institutions and sheltered workshops. The time is long overdue for a clear and comprehensive national mandate for the elimination of discrimination against persons with disabilities. The Americans with Disabilities Act will provide a tool for already existing activists, encouragement for the downtrodden and an opportunity to reach the most segregated members of our society.

House Oversight Hearing at 65.

Joseph Reum, the Commissioner of the Indiana Department of Mental Health, submitted the following statement to Congress:

[T]he segregation, the stigmatization of people with disabilities has been even greater for people with disabilities such as mental retardation, cerebral palsy, mental illness and now most recently people with AIDS. We have experienced a segregation which shuts away the humanity, the vulnerability we represent to society. We have been institutionalized, we have been sheltered, we have had our choices limited by those who felt more competent under provisions of substituted judgment. This legislation sets many people free who challenge the best of our society to represent the dignity and integrity of the individual.

House Education and Labor Hearing at 22.

State officials also testified on the substantial cost savings of integrating people with disabilities into society and out of institutions and nursing homes. Greg Fehribach, the Chairman of the Indiana Governor's Council on People with Disabilities, stated, "Those who feel it is cheaper to institutionalize a citizen than it is to work side by side with that same citizen have a false perception ... Institutionalization is not fair nor is it accommodating." *Id.* at 8. Elmer Bartels, the Commissioner of the Massachusetts Rehabilitation Commission, testified that "in vocational rehabilitation and independent living ... we provide a reasonable level of services that cost less where people can live independently in the community than it costs to keep people in dependent settings within nursing homes, public health hospitals and institutions." House Oversight Hearing at 29.

## II. OFFICIAL REPORTS CONGRESS USED TO DOCUMENT THE HISTORY OF UNNECESSARY SEGREGATION AND INSTITUTIONALIZATION OF PEOPLE WITH DISABILITIES

### REPORT OF THE UNITED STATES COMMISSION ON CIVIL RIGHTS

The United States Commission on Civil Rights' 1983 report, *Accommodating the Spectrum of Individual Abilities*, recognized the harm unnecessary removal from society wreaks on people with disabilities:

The harshest side of institutionalization is the systematic placement of handicapped people in substandard residential facilities, where incidents of abuse by staff and other residents, dangerous physical conditions, gross understaffing, overuse of medication to control residents, medical experimentation, inadequate and unsanitary food, sexual abuses, use of solitary confinement and physical restraints, and other serious deficiencies and questionable practices have been

reported. But even the better institutions suffer the ill effects of segregation:

Institutions serve two central purposes. First, they segregate disabled people from the community; and second, they provide convenience for administrators and instructional personnel because children with a given disability are concentrated together and readily accessible. As instruments of segregation, institutions are undeniably effective. Typically located in rural areas, they become small worlds unto themselves. As vehicles of administrative convenience, they are equally successful ... As settings for individual growth and development, however, institutions may be the worst possible arrangement.

UNITED STATES COMM'N ON CIVIL RIGHTS, ACCOMMODATING THE SPECTRUM OF ABILITIES 33 (1983) ("Civil Rights Report"), quoting Frank Bowe, HANDICAPPING AMERICA, BARRIERS TO DISABLED PEOPLE 143-44 (1978). The report continued that institutionalization of people with disabilities persisted in America:

Indeed, a desire to segregate handicapped people from the rest of society prompted the development of residential institutions. This segregationist purpose still operates, one authority on institutions has contended:

The complementary goals of isolation and segregation are still pursued today. Old institutions are still being enlarged; and despite the fact that normalizing community services have been shown to be less expensive than institutional services, new institutions are still being built for upwards of 1,000 residents ...



This continued expansion of uneconomic institutional services can only be interpreted as an expression of the desire on the part of society and those responsible for the delivery of services to continue to segregate and dehumanize mentally retarded individuals.

Civil Rights Report at 34, quoting Affidavit of W. Wolfensberger, Maryland Ass'n for Retarded Children v. Maryland, CA No. 72-733-M (Md. Cir. Ct. Baltimore City Apr. 9, 1974) at 8.

The Commission's report described the policies of segregation and exclusion within the context of the pervasive history of discrimination against people with mental retardation. The Commission linked the maltreatment and institutionalization of people with mental retardation today to the turn-of-the-century movement to "cleanse" society of people with mental and physical disabilities:

The Social Darwinism of the late 19th century spawned a eugenics movement, which peaked in the United States in the 1920s. This movement was based on the notion that mental and physical disabilities were the underlying source of nearly all social problems and were occurring with ever-increasing frequency due to reproduction by unfit persons. Some observers saw the spreading of handicapping conditions through heredity as the single most serious problem facing America. Handicapped individuals were frequently referred to as "mere animals," "sub-human creatures," and "waste products" which were draining the economy and producing only "pauperism, degeneracy, and crime."

To isolate handicapped people, some professionals advocated institutionalization for even minor disabling conditions. The costs of maintaining the institutions,

however, soon became burdensome for many communities. Reducing per capita costs allowed institutions to admit more people on a given budget. These economies of scale fostered large, understaffed institutions often providing minimal custodial services to residents.

Civil Rights Report at 19-20. The report continued to describe the development into the 20th Century of the segregationist mentality and its domination of American society's view toward people with mental retardation:

Institutionalization had become American society's automatic response to the question of how to deal with the handicapped population:

[W]hether young or old; whether borderline or profoundly retarded; whether physically handicapped or physically sound; whether deaf or blind; whether rural or urban; whether from the local town or from 500 miles away; whether well-behaved or ill-behaved[,] [w]e took them all, by the thousands, 5,000 to 6,000 in some institutions. We had all the answers in one place, using the same facilities, the same personnel, the same attitudes, and largely the same treatment.

Civil Rights Report at 20-21, quoting Wolf Wolfensberger, The Origin of Our Institutional Models, PRESIDENT'S COMM. ON MENTAL RETARDATION, CHANGING PATTERNS IN RESIDENTIAL SERVS. FOR THE MENTALLY RETARDED 143 (1969).

#### REPORTS OF THE NATIONAL COUNCIL ON DISABILITY

In its 1984 amendments to the Rehabilitation Act, Congress created the National Council on the Handicapped, later renamed

the National Council on Disability, to "promote policies, programs, practices and procedures that ... empower individuals with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society." 29 U.S.C. § 780 (historical note). Congress would use the National Council's first and second reports as the foundation for the Act. H.R. Rep. 101-485(II), 1990 U.S.C.C.A.N. at 310; Weicker at 390.

The National Council's 1986 report, *Toward Independence*, reported on the need to establish services that integrate rather than exclude and segregate people with disabilities. The report opens with a recognition of Congress' findings when enacting the 1973 Rehabilitation Act:

[I]t is essential ... that the complete integration of all individuals with handicaps into normal community living, working, and service be held as the final objective (29 U.S.C. section 701 note, (1976)).

NATIONAL COUNCIL ON THE HANDICAPPED, TOWARD INDEPENDENCE A-3 (1986)("Toward Independence"). The Report also begins by citing an article recommending integration of people with disabilities over the "custodial" model of services:

The older custodial attitude is typically expressed in policies of segregation and shelter, of special treatment and separate institutions. The newer integrative approach focuses attention upon the needs of the disabled as those of normal and ordinary people caught at a physical and social disadvantage. The effect of custodialism is to magnify physical differences into qualitative distinctions; the effect of integrationism is to maximize similarity, normality, and equality as between the disabled and the able-bodied.

Toward Independence at A-2, quoting ten Broek & Matson at 816.

In Part G of the report, the National Council discusses the need to promote independent community living and end the large-scale unnecessary segregation of persons with disabilities in institutions:

Community-based services that promote independence for Americans with disabilities is a promising strategy for our nation. Environmental inaccessibility, overprotective and restrictive attitudes on the part of relatives and providers, lack of economic resources, ignorance of the concepts and techniques of independent living, lack of community based support services, and a bias toward institutions in current service-providing systems, however, restrict the ability of many persons with disabilities to achieve and maintain maximum independence. Billions of public dollars are currently spent on maintaining millions of disabled Americans in situations of unproductive dependency, which impose artificial limits on disabled individuals' potential to become contributing members of society. Significant savings will be realized as America moves toward becoming an accessible society, and as more severely disabled people become independent, contributing citizens.

The Council believes that the majority of persons with disabilities are able to sustain themselves and contribute to society provided that accessible facilities and services are available and they are assisted with overcoming the attitudes and barriers that unnecessarily restrict and prohibit them from attaining their goals for self-sufficiency and independence ... When appropriate services and assistance are available, few individuals with severe disabilities should be placed in institutions.



Toward Independence at G-1 & G-2. The Council emphasized that all persons with disabilities, including those with severe disabilities, could benefit from integration, rendering their segregation in institutions unnecessary:

Who can use community-based independent living support services? Almost all persons residing in private and government-operated institutions, regardless of the severity of their disability, could benefit in some way from independent living support services. For a large percentage, it could mean being able to live in the community in a residence and lifestyle of their own choice and with the opportunity to realize their potential for productive contributions to society. For those with the most severe disabilities, it could mean receiving life support and enrichment in a dignified and humane manner that maximizes their quality of life.

Id. at G-3 & G-4. The Council also noted studies and surveys showing that only four percent of persons with mental retardation living in community programs were without a major day activity. The Council also found that unlike institution residents, community program residents use pre-existing community resources available to all, "for it would be contrary to the purpose of small, homelike facilities to have all services provided in-house as they are in large institutions." Id. at G-24 & G-25.

President Reagan praised *Toward Independence* and endorsed its findings:

I agree with the goals in *Toward Independence*--equal opportunity and full social participation for all Americans, and I am pleased to see that your report sets forth a comprehensive agenda for progress toward these goals ... The road toward full independence will not be easy.

Letter of Jan. 26, 1986 from President Ronald Reagan to Sandra S. Parrino, Chairperson, Nat'l Council on the Handicapped, quoted in NATIONAL COUNCIL ON DISABILITY, ON THE THRESHOLD OF INDEPENDENCE (1988).

The Council's second report, *On the Threshold of Independence*, built on the findings of *Toward Independence* and proposed a comprehensive civil rights bill for people with disabilities, which Congress would enact as the Americans with Disabilities Act of 1990.

## **APPENDIX F**



## APPENDIX F

### AVERAGE PER CAPITA COST OF PUBLIC INSTITUTIONS AND HOME AND COMMUNITY-BASED WAIVER PROGRAMS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES BY STATE<sup>1</sup>

| State                       | 1996 Per Capita Cost:<br>Home/Community-Based<br>Waiver Program | 1996 Per Capita<br>Cost:<br>Public Institutions |
|-----------------------------|---|---|
| Alabama                     | \$15,491  | \$84,403  |
| Alaska                      | 35,501  | 253,462 <sup>2</sup>                            |
| Arizona                     | 27,440  | 61,239  |
| Arkansas                    | 29,447  | 60,485  |
| California                  | 11,663  | 108,695   |
| <b>Colorado<sup>3</sup></b> | <b>32,783</b>   | <b>105,174</b>                                  |
| Connecticut                 | 49,428  | 140,720   |
| Delaware                    | 33,400  | 104,866   |
| Florida                     | 11,342  | 77,097  |
| <b>GEORGIA</b>              | <b>\$34,217</b>   | <b>\$84,275<sup>4</sup></b>                     |

<sup>1</sup> Source: BRADDOCK ET AL., THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES (1998).

<sup>2</sup> Alaska plans to close its one remaining institution, which housed 28 people in 1996.

<sup>3</sup> States listed in bold are the minority of states supporting Petitioners in this action.

<sup>4</sup> In 1996, Georgia housed 1,961 of its citizens with developmental disabilities in public institutions and 1,897 in nursing homes, giving it the ninth-highest percentage of people living in large

| State         | 1996 Per Capita Cost:<br>Home/Community-Based<br>Waiver Program | 1996 Per Capita<br>Cost:<br>Public Institutions |
|---------------|---|---|
| Hawaii        | \$23,358  | \$144,241                                       |
| Idaho         | 21,678  | 148,131   |
| Illinois      | 13,974  | 82,339  |
| Indiana       | 29,923  | 87,749  |
| Iowa          | 12,667  | 94,999  |
| Kansas        | 22,770  | 99,578  |
| Kentucky      | 30,000  | 69,613  |
| Louisiana     | 20,174  | 68,449  |
| Maine         | 46,417  | 150,353   |
| Maryland      | 37,743  | 104,519   |
| Massachusetts | 30,547  | 164,169   |
| Michigan      | 30,413  | 146,975   |
| Minnesota     | 39,695  | 161,110   |

segregated facilities. On a per capita basis, Georgia places fewer of its citizens with developmental disabilities than any other state except for Mississippi. At the same time, Georgia's per capita spending for its HCBW program was less than half the national average in 1996. THE STATE OF THE STATES at 173.

| State          | 1996 Per Capita Cost:<br>Home/Community-Based<br>Waiver Program | 1996 Per Capita<br>Cost:<br>Public Institutions |
|----------------|---|---|
| Mississippi    | \$4,122 <sup>5</sup>  | \$73,021  |
| Missouri       | 9,763   | 97,041  |
| Montana        | 24,139  | 96,946  |
| Nebraska       | 24,751  | 60,540  |
| Nevada         | 12,440  | 101,378   |
| New Hampshire  | 38,338  | 0 <sup>6</sup>                                  |
| New Jersey     | 29,350  | 74,330  |
| New Mexico     | 30,871  | 168,316 <sup>7</sup>                            |
| New York       | 40,738  | 131,833   |
| North Carolina | 18,546  | 94,688  |
| North Dakota   | 16,064  | 135,233   |
| Ohio           | 36,383  | 101,166   |
| Oklahoma       | 37,179  | 100,035   |

<sup>5</sup> Mississippi ranks last among the states in HCBW spending and was one of the last states to establish an HCBW program. The program began in 1996 and served only 44 people that year. On a per capita basis, Mississippi places fewer of its citizens in the community than any other state in the country. Additionally, Mississippi is one of only seven states that spends more on institutional care than on community programs. THE STATE OF THE STATES at 285.

<sup>6</sup> Has no public institutions for persons with developmental disabilities.

<sup>7</sup> On July 21, 1997, New Mexico closed the Los Lunas Developmental Center and currently has no public institutions for persons with developmental disabilities. THE STATE OF THE STATES at 341.



| <b>State</b>          | <b>1996 Per Capita Cost:<br/>Home/Community-Based<br/>Waiver Program</b> | <b>1996 Per Capita<br/>Cost:<br/>Public Institutions</b> |
|-----------------------|--|--|
| Oregon                | \$27,724   | \$179,933  |
| Pennsylvania          | 50,932   | 95,456   |
| Rhode Island          | 40,267   | 0 <sup>8</sup>   |
| <b>South Carolina</b> | <b>14,259</b>  | <b>78,090</b>  |
| South Dakota          | 24,489   | 82,368   |
| <b>Tennessee</b>      | <b>24,542</b>  | <b>97,246</b>  |
| <b>Texas</b>          | <b>26,643</b>  | <b>66,264</b>  |
| Utah                  | 18,608   | 92,371   |
| Vermont               | 41,168   | 0 <sup>9</sup>   |
| Virginia              | 32,064   | 73,130   |
| Washington            | 23,865   | 108,255  |
| West Virginia         | 27,552   | 164,144  |
| Wisconsin             | 25,795   | 100,493  |
| <b>Wyoming</b>        | <b>33,560</b>  | <b>111,194</b>   |

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<sup>8</sup> Has no public institutions for persons with developmental disabilities.

<sup>9</sup> Has no public institutions for persons with developmental disabilities.

19  
No. 98-536

Supreme Court, U. S.  
FILED

FEB 4 1999

CLERK

IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1998

TOMMY OLMSTEAD, Commissioner of the Department of  
Human Resources of the State of Georgia, et al.,

*Petitioners,*

—v.—

L.C. and E.W., each by JONATHAN ZIMRING,  
as guardian ad litem and next friend,

*Respondents.*

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES  
COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

**AMICUS CURIAE BRIEF OF THE VOICE  
OF THE RETARDED, ET AL.,  
IN LIMITED SUPPORT OF AFFIRMANCE\***

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32/29



**LIST OF AMICI**

Abilene Texas State School Parents Association  
Action for RHCs (WA)  
Allegheny Valley School (PA)  
Alliance of Louisiana Schools for the Mentally Retarded  
Altoona-Cresson-Ebensburg Centers Association (PA)  
American Federation of State, County and Municipal  
Employees, AFL-CIO  
The Arc of Mercer County  
Arkadelphia Human Development Center Parents  
Group (AR)  
Arkansas Advocates for Human Development Center  
Residents  
Associates in Communication Therapies, PC (TN)  
Association for Hunterdon Developmental Center (NJ)  
Association for the Mentally Retarded of Agnews (CA)  
Association of Retarded Citizens – Santa Clara  
County (CA)  
Austin State School Parent Association (TX)  
Autism Research Institute  
Autism Society of Pennsylvania  
Autism Society of Pittsburgh, Inc. (PA)  
Beatrice State Developmental Center Parents  
Association (NE)  
Beverly Farm Foundation (IL)  
Booneville Human Development Center Parent  
Association (AR)

Booneville Human Development Center Volunteer Council (AR)  
 Brian's House (PA)  
 California Association of Psychiatric Technicians  
 California Association of State Hospital Parent Councils for the Retarded  
 Care Management, Inc. (LA)  
 Clearbrook (IL)  
 Clover Bottom Developmental Center Parent-Guardian Association (TN)  
 Coalition of Families and Advocates for the Retarded (MA)  
 Common Thread (AR)  
 Concerned Families of Hazelwood Facility (KY)  
 Conway Human Development Center Parent Association (AR)  
 Corpus Christi State School Parents Association (TX)  
 Denton State School (TX)  
 Developmental Disabilities Health Alliance (NJ)  
 The Dever Association (MA)  
 Divine Providence Village (PA)  
 Dixon Association for Retarded Citizens (IL)  
 The Family Association of Brenham State School (TX)  
 Fairview Families and Friends, Inc. (CA)  
 Families and Friends United for Central Virginia Training Center for the Mentally Retarded (VA)  
 Families United Incorporated (OH)

Fernald League for Retarded Children (MA)  
 Florida's Voice of the Retarded  
 Frances Haddon Morgan Center Parent Association (WA)  
 Friends and Families of the Black Mountain Center (NC)  
 Friends of Anne Grady Center (OH)  
 Friends of Choate (IL)  
 Friends of Fircrest (WA)  
 Friends of the Jacksonville Developmentally Disabled (IL)  
 Friends of Rainier, Inc. (WA)  
 Friends of Retarded Citizens of Connecticut, Inc.  
 Friends of Tarwater (AL)  
 Glavin Association for the Retarded (MA)  
 Glenwood Citizen Advisory Board (IA)  
 Glenwood Parent Family Association (IA)  
 Good Shepherd Manor (IL)  
 Great Oaks Association, Inc. (MD)  
 Green Line Parent Group, Inc. (CA)  
 Greentree Applied Systems, Inc. (KY)  
 The Harris Group (VA)  
 Hilltoppers, Inc. (TN)  
 The Home and School Association of Southbury Training School (CT)  
 Howe Association for Retarded Citizens (IL)  
 Illinois League of Advocates for the Developmentally Disabled



Jonesboro Human Development Center Parents' Group  
 (AR)  
 Kankakee Association for the Mentally Retarded (IL)  
 Lakeland Village Association (WA)  
 Lake Owasso Parent Group (MN)  
 Landmark Supporters (FL)  
 Lawrence County Association for Retarded Citizens (PA)  
 Lincoln Parents' Association of Lincoln Illinois  
 Developmental Center  
 Link Associates (IA)  
 Lubbock State School Parent Association (TX)  
 Lufkin State School Parents Association for the Retarded  
 of Texas (TX)  
 Meadows Parents Association (IL)  
 Melmark, Inc. (PA)  
 Mental Retardation Association of Missouri  
 Mental Retardation Association of Nebraska  
 Mental Retardation Association of Utah  
 Mexia State School Parents Association (TX)  
 Misericordia Family Association (IL)  
 Mount St. Joseph Association (IL)  
 National Alliance Of The DisAbled, Inc.  
 New Mexico Parents and Guardians for Persons with  
 Developmental Disabilities  
 North Mississippi Regional Center  
 North Mississippi Regional Center Parents and Friends  
 Organization

North Star West Crime Watch (TX)  
 Northern Wisconsin Center Parents Group  
 The Office Inc. (TX)  
 Ohio League for the Mentally Retarded  
 Oregon Voice of the Retarded  
 Parent and Guardian Association of the Coastal  
 Center (SC)  
 Parent Association of Northwest Louisiana  
 Developmental Center  
 Parent Association for the Retarded of Texas  
 Parent Committee of Southern Wisconsin Center for  
 Developmentally Disabled  
 Parent Guardian Association of Arlington Developmental  
 Center (TN)  
 Parent Hospital Association – Sonoma Developmental  
 Center (CA)  
 Parent-Relative Organization for Oakwood  
 Facilities, Inc. (KY)  
 Parents and Associates of Northern Virginia Training  
 Center  
 Parents and Associates of the Institutionalized Retarded  
 of Virginia  
 Parents and Friends Association Selingsgrove Center (PA)  
 Parents and Friends of Hammond Developmental Center  
 Association (LA)  
 Parents and Friends of Ludeman (IL)  
 Parents and Friends of Monson Developmental  
 Center (MA)  
 Parents Association Boswell Center, Incorporated (MS)

Parents Association of St. Louis State School and  
 Hospital, Inc./Bellefontaine Habilitation Center (MO)  
 Parents Committee – Central Wisconsin Center for the  
 Developmentally Disabled  
 Parents Coordinating Council and Friends (CA)  
 Parents of Adult Children Concerned for Tomorrow (IL)  
 Parents of Woodhaven Incorporated (PA)  
 Parents, Relatives and Friends of Polk (PA)  
 Pennsylvania League of Concerned Families of  
 Retarded Citizens  
 Pinecrest Parent's Association (LA)  
 Pleasant Manor Parents Advisory Board, Inc. (PA)  
 Porterville Developmental Center Parents Group, Inc. (CA)  
 ProCare3 (NE)  
 Relatives and Friends Association of White Haven  
 Center (PA)  
 Richmond State School Parents' Association (TX)  
 River Valley Accessibility Council (AR)  
 Rosewood Center Auxiliary, Inc. (MD)  
 Sacramento Association for the Retarded (CA)  
 Save Agnews Now (CA)  
 South Mississippi Regional Center Parent Association  
 Southwest State School Parents Association (LA)  
 Tallahassee Developmental Center Advocates (FL)  
 Texans Supporting State Schools  
 Texas State Employees Union/Communication Workers of  
 America – Local 6186

Valley Association for Retarded Children and Adults (CT)  
 Village Northwest Unlimited (IA)  
 Washington State Veterans of Foreign Wars  
 Waukegan Development Center Association for Retarded  
 Citizens (a/k/a Kiley Parents' Association) (IL)  
 Wendell Foster Center, Inc. (KY)  
 Western Center Parents Group (PA)  
 Wisconsin Parents Coalition for the Retarded, Inc.  
 Woods Services, Inc. (PA)  
 Wisconsin State Employees Union, American Federation  
 of State, County, & Municipal Employees, Council 24  
 Woodbridge Developmental Center Parents  
 Association (NJ)  
 Woodward State School and Home Association (IA)  
 Wrentham Association for the Retarded (MA)  
 American Health Care Association  
 Families and Friends Association of Hamburg Center



## TABLE OF CONTENTS

|   | PAGE |
|---|------|
| List of <i>Amici</i> .....  | i    |
| Table of Cited Authorities .....  | ix   |
| Preliminary Statement .....   | 1    |
| Interest of the VOR <i>Amici</i> .....  | 1    |
| Summary of Argument .....   | 2    |
| Argument:   |      |
| I. THE OPTION OF INSTITUTIONAL<br>PLACEMENT IS PRESERVED UNDER<br>THE ADA ..... | 3    |
| A. Introduction: The National Debate .....                                      | 3    |
| B. ADA Provisions .....   | 4    |
| 1. Overview .....   | 4    |
| 2. Role of the Institution .....  | 4    |
| 3. Degrees of Disability .....  | 5    |
| 4. Government Interpretations .....   | 6    |
| 5. Summary .....  | 7    |
| C. The Alarming Dicta Below .....   | 8    |
| Conclusion .....  | 12   |

## TABLE OF CITED AUTHORITIES\*

| Cases:   | PAGE                 |
|--|----------------------|
| <i>Alexander v. Choate</i> , 469 US 287 (1985) .....   | 4                    |
| <i>Easley v. Snider</i> , 36 F. 3d 297 (3 Cir. 1994) ....  | 2, n.4; 8, n.8       |
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| <i>People First of Washington, Inc. v. Rainer Residential</i><br><i>Habilitation Center, et al.</i> , No. C 96-5906 FDB<br>(WD Wash. 1997) .....                                       | 3                    |
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| Statutes and Regulations:  |                      |
| 42 USC § 6000(c)(3) .....  | 2, n.3               |
| 42 USC § 12101(a)(1) .....   | 1, n.2; 5            |
| 42 USC § 12101(a)(2) .....   | 5                    |
| 42 USC § 12101(a)(3) .....   | 4; 5; 10             |
| 42 USC § 12111(8) .....  | 5                    |
| 42 USC § 12131(2) .....  | 5                    |

\* Excluding the cases listed in n. 3, *infra*, which only identify cases in which this *amicus curiae* has appeared.

|   | PAGE   |
|---|--------|
| 42 USC § 12182(b)(1)(B) .....   | 5      |
| 42 USC § 12201(d) .....   | 7, n.7 |
| 104 Stat. 327 .....   | 4      |
| 28 CFR 35.130(d) .....  | 6      |
| <b>Other:</b>   |        |
| USCC Rule 37.3(a).....  | 1      |
| USCC Rule 37.6 .....  | 1, n.1 |
| House Report, P.L. 103-230 .....  | 6-7    |
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## Preliminary Statement

This is an *amicus curiae* brief on the merits, submitted upon the consent of both parties pursuant to this Court's Rule 37.3(a). (App. at 1a-2a.) Prepared by Voice of the Retarded ("VOR"),<sup>1</sup> it is adopted by 141 organizations advocating the rights of the disabled.<sup>2</sup>

## Interest of the VOR Amici

VOR is an advocacy organization incorporated in Illinois, dedicated to insuring that individuals with mental retardation receive the care and support they require in a setting appropriate to their needs. Depending on the unique condition of each disabled person, that appropriate setting could be community placement, as respondents argue here, or institutionalization, as petitioner Georgia urges. A spectrum of choices must be available, because not every disability lends itself to community placement.

The unique perspective VOR offers in this litigation is the applicability of the Americans With Disabilities Act, 42 USC §§ 12101 *et seq.* ("ADA"), to one placement option, institutionalization.<sup>3</sup> VOR agrees with the Court of Appeals that

<sup>1</sup> Pursuant to this Court's Rule 37.6, VOR represents that no counsel to any party authored this brief, in whole or in part. Counsel to the VOR have acted *pro bono*. Disbursements have been paid only by VOR.

<sup>2</sup> Their names begin at p. i, *supra*. They do not include organizations such as ADAPT (American Disabled for Attendant Programs Today), whose confrontational tactics are rejected by VOR. (See App. to Florida Amicus Brief ["Fla. App."], at 17a-21a.) We trust that common goals advancing the interests of America's 43 million disabled (42 USC § 12101[a][1]) will appear from this brief.

<sup>3</sup> VOR also advances family participation in the choice of treatment options, with the decisions of the disabled person and her family recognized as primary. VOR has previously presented this position to this Court for 100 amici in *Heller v. Doe*, 509 US 312 (1993), and as supporters of petitioner in *People First of Tennessee v. Arlington Develop-*



institutionalization is a permissible choice under the ADA when warranted by the facts of a particular case. VOR is troubled by *dicta* in the Court of Appeals opinion which appear to threaten elimination of this placement option—a position which we submit is at odds with the ADA.<sup>4</sup>

### Summary of Argument

The ADA has always permitted institutional placement, as long as it was the least restrictive alternative available (or the most integrated setting appropriate), upon the medical, behavioral and care needs of the disabled person involved. The safety and constant monitoring provided by an institution presents one care option envisioned by the ADA to insure maximum possible self-reliance for disabled people. Ideally, some of those people could even progress to community placement. (Point I, below.)

---

*mental Center*, No. 97-5232 (6 Cir.; May 7, 1998; unpublished); *cert. denied*, \_\_\_ US \_\_\_ (Nov. 16, 1998). It has also similarly appeared before the Supreme Judicial Court of Massachusetts in *Judge Rotenberg Educational Center, Inc. v. Campbell*, No. 17101-Bristol, and in the District Court in *Cramer v. Chiles*, No. 96-6619 CIV-FERGUSON (SD Fla. 1998). VOR's position on family participation was enacted as a statement of policy in the Developmental Disabilities and Bill of Rights Act Amendments of 1994, codified at 42 USC § 6000(c)(3).

<sup>4</sup> Given the conflicting *dicta*, VOR submits that a clear statement is urgently needed from this Court that institutional placement is an available option under the ADA when medical facts preclude community placement. See *Easley v. Snider*, 36 F. 3d 297 (3 Cir. 1994).

## ARGUMENT

### I. THE OPTION OF INSTITUTIONAL PLACEMENT IS PRESERVED UNDER THE ADA.

#### A. Introduction: The National Debate

"Disability" should not be a collective noun. There are degrees of disability, and differences in the appropriate treatment of disability. Community placement may well be an effective option for those whose disabilities are less severe. For many of the severely disabled, however, institutional placement is the best possible caregiving choice.

The essence of the problem was sensitively captured by District Judge Franklin D. Burgess in *People First of Washington, Inc. v. Rainier Residential Habilitation Center, et al.*, No. C96-5906 FDB (WD Wash 1997):

"[Intervenor] explains that there is 'a great debate' in this country about how to best treat, care for, and accommodate the mentally retarded and developmentally disabled. On one side are those who say that large, institutionalized care is inhumane, unnecessarily restrictive, and violative of human rights, and that all developmentally disabled persons should be placed in small, community based programs. On the other side are those who say that a 'continuum' of care is more appropriate, that is, that while some disabled persons can function in community settings, others are so severely disabled that, for them, an institution with centralized, constant protection and care is a better alternative. [Intervenor] acknowledges that on both sides are experts, examples of failure, and families with difficult choices and hard feelings."

VOR advocates preservation of the choice of institutional placement, without eliminating the option of community

placement.<sup>5</sup> We further submit that each choice is available under the ADA.

## B. ADA Provisions

### 1. Overview

Liberation from the effects of disability is the major thrust of the ADA. The ramps it requires; the physical barriers it removes; the platform lifts it installs—all serve to transform a wheelchair into a chariot. VOR warmly endorses this result.

As applied to caregiving options, the ADA insures that there will be no more Willowbrooks. Never again can the severely disabled be “shunted aside, hidden and ignored”. *Alexander v. Choate*, 469 US 287, 296 (1985). Here, again, VOR applauds the result.

But there are disabled people who cannot use a wheelchair, or safely move into the community. Does the liberating thrust of the ADA force those people from a protecting institution? From this perspective, VOR approaches the statute.

### 2. Role of the Institution

The ADA mentions the institutional placement option only once, at 42 USC § 12101(a)(3). The statutory pattern is clear.

Congress begins the ADA with a description:

“An Act to establish a clear and comprehensive *prohibition of discrimination* on the basis of disability.” (104

<sup>5</sup> Those who advocate elimination of either of these choices recently found their position harshly paraphrased:

“[L]aw-and-order conservatives want people permanently locked up, and nurturing liberals want more community-based services and housing, but bridle at restrictions on patients’ personal liberties.”

(Satel, *Real Help for the Mentally Ill*; New York Times, 1/7/99, p. A 31, col. 3.) VOR endorses Judge Burgess’ expression of the agonizing choices presented.

Stat. 327, preceding enactment language; emphasis added.)

The statute then makes several “findings”. It begins with the number of disabled nationwide. (42 USC § 12101[a][1].) It then recites that disabled individuals have suffered discrimination through isolation, and segregation from outside society. (42 USC § 12101[a][2].) The statute next finds that this discrimination “persists in...critical areas”, specifying eleven. The eighth of these is “institutionalization”. (42 USC § 12101[a][3].)

A listing of the other ten areas provides the context. They are:

“employment, housing, public accommodations, education, transportation, communication, recreation, . . . health services, voting, and access to public services.” (*Ibid.*)

Nowhere does the statute fault any of these “critical areas”. The existence of a workplace, or a train, or a stadium, is not a violation *per se*; the statute attacks any discrimination occurring there. The presence of an institution is not condemned by the ADA, any more than a polling booth is.

### 3. Degrees of Disability

The ADA recognizes that some people are more disabled than others. This conclusion follows from the statutory term “qualified individual with a disability” (42 USC §§ 12111[8] and 12131[2]; emphasis added), and also from the public accommodation title of the ADA, requiring:

“the most integrated setting *appropriate to the needs of the individual*.” (42 USC § 12182[b][1][B]; emphasis added.)

These are separate concepts: an individual qualified for (*i.e.*, eligible to profit from) an accommodation, and a setting



appropriate for (*i.e.*, capable of satisfying) the individual's needs. As applied to this appeal, one conclusion seems plain: some disabled individuals can benefit from community placement, and some may not. While all disabled are covered by the ADA, different remedies are recognized by the statute for different degrees of disability.

#### 4. Government Interpretations

Regulatory history following the enactment of the ADA supports this basic analysis. The "integration regulation" blends the concepts of "qualified individual" and "appropriate setting". As applied here, the regulation required Georgia to provide caregiving services:

"in the most integrated setting appropriate to the needs of qualified individuals with disabilities." (28 CFR 35.130[d], reproduced at Pet. App. 45a.)

The analysis accompanying the integration regulation (Pet. App. at 47a-50a) acknowledges the need for "separate programs in limited circumstances" (*Ibid.* at 48a).

A separate but unrelated law was enacted four years after the ADA, entitled "The Developmental Disabilities Assistance and Bill of Rights Act", 42 USC § 6000 *et seq.* The House Report accompanying certain 1994 amendments to that statute offers an even clearer statement in support of institutional care for some people with disabilities:

"The Committee recognizes that, with the appropriate resources and support, many individuals with developmental disabilities will live lives that are fully integrated into their respective communities. This potential, however, should not be seen as limiting the choice of individuals and their parents to seek living arrangements that are most suitable to their needs and wishes, *whether they be in the community or in institutions.*" (App. at 4a; emphasis added.)

With unmistakable directness, the House Report advises:

"[T]he Committee would caution that the goals expressed in this Act to promote the greatest possible integration and independence for some individuals with developmental disabilities *not be read as a Federal policy supporting the closure of residential institutions.* It would be contrary to Federal intent to use the language or resources of this Act to support such actions. . .". (*Ibid.*; emphasis added.)

Statutes and regulations are implemented upon the real experience of actual citizens. So it has been here. Six months ago, a federal official charged with ADA enforcement duties, Sally K. Richardson, reviewed recent precedent, including the decision below, and pressed the community placement option. (Fla. App. at 1a-4a.) VOR promptly requested a clarification that "institutional care" was still an option.<sup>6</sup> (App. at 5a-6a.) The government's response was direct and correct:

"I agree with you that the law is sufficiently clear that institutional services must be offered to individuals who wish to receive services in an institutional setting, [when] that setting is the 'most integrated setting appropriate to the needs of the individual'." (App. at 7a.)<sup>7</sup>

#### 5. Summary

This Court may safely assume that all disabled welcome the maximum liberty which their condition permits. The differ-

<sup>6</sup> In response to the Richardson letter, the National Association of State Medicaid Directors referred to "the current entitlement to institutional care". (Fla. App. at 15a-16a.) This reaction correctly reflected pre-ADA law. See *Pennhurst State School and Hospital v. Halderman*, 451 US 1, 24 (1981).

<sup>7</sup> Under the ADA, a disabled individual offered community placement is free to reject it in favor of institutional care. See 42 USC § 12201(d).

ence is medical: not all disabilities permit community placement. Only those "qualified individuals" may be so placed.

VOR submits that the ADA permits the conclusion that an institutional placement can be the "most integrated setting appropriate" for severely disabled individuals. This position appears to be consistent with the views of Georgia; of the states joining in the Florida *amicus curiae* brief, and of the Court of Appeals below. (Pet. Brief at 8; Fla. Brief at 11-12; Pet. App. at 21a and 30a, n. 10.)<sup>8</sup> It does not appear to be inconsistent with the position of respondents, who did not advocate institutional closure below.

### C. The Alarming Dicta Below

The Court of Appeals was not presented with the availability of the institutional placement option under the ADA. Georgia conceded that respondents "could have been discharged to a highly structured community placement". (Petition at 3; Pet. App. at 22a, 35a.) Upon this concession, VOR supports affirmance.<sup>9</sup>

As the Court of Appeals analyzed the issue, the question considered was whether the ADA prohibited institutional placement when community placement was available, and more appropriate. (Pet. App. at 4a.) VOR presents the converse: does the ADA permit institutional placement if

<sup>8</sup> It is also consistent with two other Court of Appeals decisions considering the issue: *Helen L. v. Di Dario*, 46 F. 3d 325, at 336 and n. 22 (3 Cir. 1995); *cert. denied sub nom. Pennsylvania Secretary of Public Welfare v. Idell S.*, 516 US 813 (1995) and *Easley v. Snider*, *supra* n. 4, and one District Court decision, *Richard S. v. Department of Developmental Services of the State of California*, 973 F. Supp. 937, 941-2 (CD Cal. 1997). No authority to the contrary has been found. See nn. 11-12, *infra*.

<sup>9</sup> VOR believes that Georgia's funding defense is more appropriately addressed by the District Court, upon the remand already ordered by the Court of Appeals. Because this Court did not grant *certiorari* for Georgia's second question presented (Petition at i), VOR does not address the Fourteenth Amendment issue raised below.

available, and more appropriate than community placement? In each case, the answer should be "yes".<sup>10</sup>

VOR submits that the Court of Appeals correctly stated the applicable law when it concluded:

"We emphasize that our holding does not mandate the deinstitutionalization of individuals with disabilities.

\* \* \*

Where there is no . . . finding . . . [that a community-based placement is appropriate for that individual] . . . nothing in the ADA requires the deinstitutionalization of that patient." (Pet. App. at 21a; see, also, 30a, n. 10.)<sup>11</sup>

Unfortunately, this proper analysis came only at the end of the ADA portion of the opinion below. It was preceded by extensive *dicta* selectively reviewing legislative history and comparing institutional placement to racial segregation. The Court of Appeals virtually endorsed community placement over institutional placement with these words:

"Placement in the community provides an integrated treatment setting, allowing disabled individuals to interact with non-disabled persons—an opportunity permitted only in limited circumstances within the walls of segregated state institutions. . .". (*Ibid.* at 8a.)

In its apparent enthusiasm for community placement, the Court of Appeals then misstated the thrust of the ADA:

<sup>10</sup> VOR's position is expressly supported by *Richard S.*, *supra* n. 8.

<sup>11</sup> This analysis matches that of the Santa Ana district court in *Richard S.*, *supra* n. 8. In pertinent part, that Court concluded:

"This Court . . . holds Title II requires public entities to administer services in the 'the most integrated setting appropriate', regardless of whether that setting is an institution or a community home." (973 F. Supp. at 941.)



"The Act's findings and legislative history make clear that Congress sought to eliminate the segregation of individuals with disabilities in passing the ADA. In enacting the ADA, Congress determined that discrimination against individuals with disabilities persists in a wide variety of areas of social life, including 'institutionalization'. . .". (*Ibid.*, at 10a-11a, citing 42 USC § 12101[a](3).)

From VOR's perspective, this language is inaccurate because it is unqualified. Community placement is a splendid idea—for those medically and emotionally able to enjoy it. But there are others whose disabilities are too severe to leave an institution safely. Those disabled are disserved by the apparent adoption of a placement goal unattainable for them.<sup>12</sup>

Balance and resolution do appear further on in the Court of Appeals opinion:

"We do not suggest that, should a trial court find that a patient, for medical reasons, needs institutionalized care, it must nonetheless order placement in a community-based treatment program.

\* \* \*

Nothing in the ADA . . . forbids a state from [placing] a patient [in] an institutionalized treatment setting, *as the patient's condition necessitates*." (Pet. App. at 24a; emphasis added.)

<sup>12</sup> In reaching this result, the Court of Appeals unduly relied on *dicta* in the Third Circuit's opinion in *Helen L.*, *supra* n. 8. However, in *Helen L.*, as here: (a) the record indicated that community placement was appropriate on plaintiff's medical facts (46 F. 3d at 329 and n. 6), and (b) the Court indicated that the ADA permitted an institutional placement in an appropriate case (46 F. 3d at 336 and n. 22). Accordingly, on its facts, *Helen L.* does not support the deinstitutionalization pressure documented in the states' *amicus* brief. (Fla. Brief at pp. 2-9, including nn. 9-10, and p. 14; see ADAPT's polemics in Fla. App., at pp. 17a-21a.)

Precisely. Accepting this analysis, this Court should reject blanket language which prefers one placement alternative and excludes citizens whom the ADA intends to help. Each disabled person is entitled to treatment in the most integrated setting possible for that person—recognizing that, on a case-by-case basis, that setting may be in an institution.

Mr. Justice Blackmun perfectly captured that alternative in his concurrence in *Youngberg v. Romeo*, 457 US 307 (1982):

"For many mentally retarded people, the difference between the capacity to do things for themselves within an institution, and total dependence on the institution for all of their needs, is as much liberty as they ever will know." (457 US at 327.)

While this Court should affirm the Court of Appeals upon Georgia's record concession, it should also confirm the availability of institutional placement upon an appropriate set of facts not presented here.

### Conclusion

For the reasons advanced above, this Court should:

1. Affirm the Court of Appeals, on the undisputed factual ground that respondents L.C. and E.W. could be placed in the community;

2. Conclude that institutional placement and community placement are each available alternatives under the ADA, with the choice dependent upon the unique medical, behavioral and care requirements of the disabled person involved;

3. Affirmatively disavow *dicta* in the Court of Appeals opinion promoting community placement as the only option under the ADA.

VOR welcomes this Court's consideration of an issue of deep concern to America's disabled.

Dated: New York, New York  
February 3, 1999

Respectfully submitted,

WILLIAM J. BURKE, ESQ.

*Counsel of Record*

*to Amicus VOR*

BURKE & STONE

400 Madison Avenue

New York, New York 10017

(212) 752-5353

*Of counsel:*

TAMIE HOPP, ESQ.

Voice of the Retarded

5005 Newport Drive

Rolling Meadows, Illinois 60008

(847) 253-6020



## **APPENDIX**

## TABLE OF CONTENTS

|  | PAGE |
|--|------|
| Appendix A Consent of Georgia Petitioners,<br>dated January 12, 1999 ..... | 1a   |
| Appendix B Consent of Respondent L.C.,<br>dated January 21, 1999 .....     | 2a   |
| Appendix C Excerpt from House Report<br>Accompanying P.L. 103-230 .....    | 3a   |
| Appendix D VOR letter to HCFA Director,<br>dated September 14, 1998 .....  | 5a   |
| Appendix E Response of HCFA to VOR,<br>dated November 13, 1998 .....       | 7a   |



1a

**APPENDIX A**

[LETTERHEAD OF DEPARTMENT OF LAW—  
STATE OF GEORGIA]

January 21, 1999

VIA FACSIMILE & U.S. MAIL - 212-753-3950

William Burke, Esq.  
Burke & Stone  
400 Madison Avenue, Ste. 1101  
New York, New York 10017

Re: *Olmstead v. L.C.*  
No. 98-536

Dear Mr. Burke:

This is to consent to the request from Tamie Hopp, Executive Director of Voice of the Retarded, for leave to file an *Amicus Curiae* brief in the above-referenced case. John C. Jones was counsel of record for the Petition for Certiorari, but I am now counsel of record.

Very truly yours,

/s/ BEVERLY PATRICIA DOWNING  
Beverly Patricia Downing  
Senior Assistant Attorney General

BPD/

## APPENDIX B

Permission for leave to file an *Amicus Curiae* brief

Return by January 22, 1999 to:

William Burke, Esq.  
Counsel for Amicus Curiae

Burke & Stone  
400 Madison Ave., Suite 1101  
New York, New York 10017  
212-752-5353  
212-753-3950 fax

On behalf of Petitioners-Appellant, I consent to Voice of the Retarded's participation in *Olmstead v. L.C.* by Zimring as *Amicus Curiae*.

|                                   |                              |
|-----------------------------------|------------------------------|
| /s/ <u>SUSAN C. JAMIESON</u>      | <u>DAVID WEBSTER</u>         |
| Susan C. Jamieson                 | With Express Consent 1/21/99 |
| Steven D. Caley                   |                              |
| Atlanta Legal Aid Society         |                              |
| Counsel for Respondents-Appellees |                              |
| Atlanta Legal Aid Society         |                              |
| 246 Sycamore Street, Suite 120    |                              |
| Decatur, Georgia 30030            |                              |

If you do *not* consent to VOR's participation as *Amicus Curiae*, please check here and return from: \_\_\_\_\_

## APPENDIX C

DEVELOPMENTAL DISABILITIES ASSISTANCE AND  
BILL OF RIGHTS ACT AMENDMENTS OF 1993

November 18, 1993—Committed to the Committee  
of the Whole House on the State of the  
Union and ordered to be printed

Mr. Dingell, from the Committee on Energy and  
Commerce, submitted the following

## REPORT

[To accompany H.R. 3505]

## SECTION-BY-SECTION ANALYSIS

Section 3 of the bill amends Section 101 of the Act to update the Findings and adds sections on Purposes and Policies of the Act. These changes reflect recent developments in the field and are consistent with other Federal disability policy. The language of Section 101 speaks of goals and priorities for individuals with developmental disabilities, but the entire section should be interpreted in the context of the policy articulated in 101(c)(2), which states that any assistance should be provided in an individualized manner, consistent with the unique strengths, resources, priorities, concerns, abilities, and capabilities of the individual.

For example, the findings state that while individuals with developmental disabilities may encounter discrimination, they have the same rights to enjoy full and productive lives as any other member of society. Individuals with disabilities often require life long specialized services, but many individuals do not have adequate access to these services. The goals of the Act include providing individuals with developmental dis-



abilities the fullest range of possibilities to live productive and integrated lives, acknowledging that each individual will have different abilities, priorities, and concerns.

The Committee recognizes that, with the appropriate resources and support, many individuals with developmental disabilities will live lives that are fully integrated into their respective communities. This potential, however, should not be seen as limiting the choice of individuals and their parents to seek living arrangements that are most suitable to their needs and wishes, whether they be in the community or in institutions.

The Committee has heard from many parents of individuals with developmental disabilities who reside in large institutional facilities. Among the concerns expressed by these parents is that the goal of independent, community-based living for some individuals not be seen as a mandate for all individuals with disabilities. The Committee recognizes and supports the belief that each individual and each respective family have different goals and needs. The Findings, Purposes, and Policies of this Act should in no way be read to support one kind of residential placement over another.

Furthermore, the Committee would caution that goals expressed in this Act to promote the greatest possible integration and independence for some individuals with developmental disabilities not be read as a Federal policy supporting the closure of residential institutions. It would be contrary to Federal intent to use the language or resources of this Act to support such actions, whether in the judicial or legislative system.

The section also amends the definition of States for purposes of the Act by clarifying that Guam is eligible to apply as a State for the University Affiliated Programs grants.

## APPENDIX D

[LETTERHEAD OF VOICE OF THE RETARDED]

COPY

September 14, 1998

Sally Richardson, Director  
Center for Medicaid and State Operations  
U.S. Department of Health and Human Services  
Health Care Financing Administration  
S-2 2612  
7500 Security Blvd.  
Baltimore, MD 21244-1850

Dear Ms. Richardson:

On July 29, 1998, you sent to all state Medicaid directors a letter summarizing three Medicaid cases related to the Americans with Disabilities Act (ADA): *L.C. & F.W. v. Olmstead*, *Helen L. v. DiDario*, and *Easley v. Snider*.

Your letter quite clearly states that the ADA, and the court rulings featured, do not "require a State to serve everyone in the community but that decisions regarding services, and where they are to be provided must be made based on whether community-based placement is appropriate for a particular individual . . ." (July 29, 1998 letter, referencing *Olmstead*). This is the essence of person-centered planning. Serving individuals according to their need and choice is the cornerstone of the Medicaid program, indeed. Freedom of choice is required by Medicaid law.

Despite the clarity of your words, your letter is being used by advocates to claim the ADA requires community placement for all individuals with developmental disabilities. These advocates claim that institutional care, even for those individuals who require that level of care, violates the ADA.

Your letter, and President Clinton's speech in conjunction with its release, are being used inappropriately and out of context.

Please issue a letter that clarifies HCFA's support for institutional care (i.e., the ICF/MR program) when that level of care is the "most integrated setting appropriate to the needs of qualified individuals with disabilities," as required by the ADA.

Ms. Richardson, thank you for attention to this request. I look forward to your response.

Sincerely,

/s/ POLLY SPARE

Polly Spare

President

Voice of the Retarded

## APPENDIX E

### [LETTERHEAD OF DEPARTMENT OF HEALTH CARE FINANCING ADMINISTRATION]

Ms. Polly Spare

President

Voice of the Retarded

5005 Newport Drive, Suite 108

Rolling Meadows, Illinois 60008

Dear Ms. Spare:

I am responding to your September 14, 1998, letter to Sally Richardson in which you express concern about public interpretation of our July 29, 1998, letter to all State Medicaid Directors. As you note, our July 29 letter was intended to provide information on recent court cases related to the Americans with Disabilities Act (ADA). We did not intend to make a policy statement concerning the Health Care Financing Administration's interpretation of the ADA.

I agree with you that the law is sufficiently clear that institutional services must be offered to individuals who wish to receive services in an institutional setting, and that setting is the "most integrated setting appropriate to the needs of the individual."

I also recognize the many concerns being raised with the recent trends involving Medicaid and the ADA. We will be working with States to ensure that State Medicaid programs provide services in the most integrated setting appropriate to the needs of individual Medicaid clients.

Thank you for your continued interest in the welfare of Medicaid consumers.



8a

Sincerely,

/s/ MARY JEAN DUCKETT  
for Richard P. Brummel  
Acting Director  
Disabled and Elderly Health  
Programs Group

No. 98-536

Supreme Court, U.S.

FILED

MAR 15 1999

CLERK OF THE CLERK

**In the  
Supreme Court of the United States**

OCTOBER TERM, 1998

**TOMMY OLMSTEAD, COMMISSIONER OF THE  
DEPARTMENT OF HUMAN RESOURCES OF THE  
STATE OF GEORGIA, ET AL.,**  
*Petitioners,*

v.

**L.C. AND E.W., EACH BY JONATHAN ZIMRING, AS  
GUARDIAN AD LITEM  
AND NEXT FRIEND,**  
*Respondents.*

ON WRIT OF CERTIORARI TO THE  
UNITED STATES COURT OF APPEALS  
FOR THE ELEVENTH CIRCUIT

**AMICI CURIAE BRIEF OF  
NATIONAL MENTAL HEALTH CONSUMERS'  
SELF-HELP CLEARINGHOUSE, ET. AL.,  
IN SUPPORT OF RESPONDENTS**

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*Counsel for Amici Curiae*

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32 pp



## TABLE OF CONTENTS

|   |    |
|---|----|
| TABLE OF AUTHORITIES .....  | ii |
| INTEREST OF AMICI CURIAE.....   | 1  |
| SUMMARY OF ARGUMENT.....  | 5  |
| ARGUMENT.....   | 6  |
| I. Personal Accounts of the Benefits of Integrated<br>Services.....   | 6  |
| A. Jane D. ....   | 7  |
| B. James Price .....  | 8  |
| C. Michael J. Kennedy .....   | 9  |
| D. Bernie S. ....   | 12 |
| E. Margaret Donahue .....   | 14 |
| F. Charles Q. ....  | 15 |
| II. Community-Based Services Allow People with<br>Disabilities to Obtain the Maximum<br>Independence and Integration while Receiving<br>Treatment and Support .....   | 18 |
| A. A Community-Based Mental Health System .....   | 20 |
| III. The Professional Literature Confirms that<br>Community-Based Mental Health Services Allow<br>for More Social Interaction with Non-Disabled<br>People, Better Recovery, and Greater Happiness<br>and Fulfillment..... | 22 |
| CONCLUSION.....   | 25 |

## TABLE OF AUTHORITIES

|  | Page(s) |
|--|---------|
| <b>BOOKS AND TREATISES</b>   |         |
| Paul J. Carling, <i>RETURN TO COMMUNITY: BUILDING SUPPORT SYSTEMS FOR PEOPLE WITH PSYCHIATRIC DISABILITIES</i> (1995).....   | 23      |
| Center for Mental Health Services, <i>Mental Health Directory</i> 1995 .....   | 20      |
| K. Jamison, <i>AN UNQUIET MIND</i> (1995) .....  | 14      |
| M. Winerip, <i>9 HIGHLAND ROAD</i> (1994) .....  | 13      |
| <b>ARTICLES</b>  |         |
| William A. Anthony, <i>Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s</i> , 16 <i>PSYCHOSOCIAL REHABILITATION J.</i> , APRIL 1993, at 11.....                     | 23      |
| Herbert Bengelsdorf, M.D. et al., <i>The Cost Effectiveness of Crisis Intervention: Admission Diversion Savings Can Offset the High Cost of Service</i> , 181 <i>J. NERVOUS &amp; MENTAL DISEASE</i> 757 (1993)..... | 19      |
| Richard D. Budson, M.D., <i>Community Residential and Partial Hospital Care: Low-Cost Alternative Systems in the Spectrum of Care</i> , 65 <i>PSYCH. QUARTERLY</i> 209 (1994).....                                   | 18      |
| Paul J. Carling, <i>Major Mental Illness, Housing, and Supports</i> , 45 <i>AM. PSYCHOLOGIST</i> 969 (Aug. 1990).....  | 24      |
| James Conroy et al., <i>A Matched Comparison of the Developmental Growth of Institutionalized and Deinstitutionalized Mentally Retarded Clients</i> , 86 <i>AM. J. MENTAL DEFICIENCY</i> 581 (1982) .....            | 24      |

|  |    |
|--|----|
| Michael J. Kennedy, <i>Turning the Pages of Life</i> in J.A. Racino, et. al., <i>HOUSING, SUPPORT, AND COMMUNITY: CHOICES AND STRATEGIES FOR ADULTS WITH DISABILITIES</i> 206 (1993) .....   | 11 |
| A. Kiesler, <i>Mental Hospitals and Alternative Care: Noninstitutionalization as potential Public Policy for Mental Patients</i> , 37 <i>AM. PSYCHOLOGIST</i> 349 (Apr. 1982) .....  | 23 |
| John Lord & Alison Pedlar, <i>Life in the Community: Four Years After the Closure of an Institution</i> , 29 <i>MENTAL RETARDATION</i> 213 (1991).....   | 24 |
| Aileen B. Rothbard & Eri Kuno, <i>The Success of Deinstitutionalization: Empirical Findings from Case Studies on State Hospital Closures</i> , <i>J. INT'L LAW &amp; PSYCHIATRY</i> , January 28, 1999, at 3-4 .....   | 24 |
| Aileen Rothbard, et al., <i>Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A Three-Year Follow Up Study</i> , <i>American Journal of Psychiatry</i> , December 9, 1998, at 2 .....   | 18 |
| <b>OTHER AUTHORITIES</b>   |    |
| A Service Development Plan for a Comprehensive System of Public Mental Health Care in Compliance with the Orders of the Court in <i>Dixon v. Sullivan and Dixon</i> , July 1991 (Approved and ordered on January 27, 1992, U.S.D.C. for the District of Columbia, Civil Action 74-285 (AR))..... | 20 |
| Te-wei Hu & Jaclyn W. Hausman, <i>Institute for Mental Health Services Research Working Paper No. 4-94, Cost-Effectiveness of Community-Based Care for Individuals with Mental Health Problems</i> (July 1994).....  | 24 |



|  |              |
|--|--------------|
| K. Charlie Lakin and Mary Hayden, Final Report to the Health Care Financing Administration: An Evaluation of Implementation of the Medicaid Community Supported Living Arrangements (CSLA) Program in Eight States (1996)..... | 20           |
| Zana Marie Lutfiyya, Center on Human Policy, <i>Reflections on Relationships between People with Disabilities and Typical People</i> (Aug. 1988) .....   | 23           |
| State of Alabama, Department of Mental Health and Mental Retardation Five Year Plan FY 93-94 to FY 97-98 .....   | 20           |
| Beth Stroul, Crisis Residential Services in a Community Support System: Report on the NIMH Crisis Residential Services Project (1987).....   | 20           |
| Telephone interview with Aimee S., mother of Bernie S. (Feb. 11, 1999) .....   | 12, 13       |
| Telephone interview with William A. Anthony, Ph.D. (Feb. 25, 1999).....  | 23, 24       |
| Telephone interview with Jacqueline Beilharz, Supervisor, Pennsylvania Protection and Advocacy (February 11, 1999).....  | 16, 17       |
| Telephone interview with Margaret Donahue (Feb. 10, 1999).....   | 14, 15       |
| Telephone interview with Diana Carra Haugh, Advocacy Specialist, Pennsylvania Protection & Advocacy (February 11, 1999).....   | 7, 8, 15, 16 |
| Telephone interview with James Price (Feb. 9, 1999).....   | 8, 9         |
| Telephone interview with Michael Kennedy (Feb. 11, 1999).....  | 9, 10, 11    |
| Barbara Wright & Martha P. King, National Conference of State Legislatures, <i>Americans with Developmental Disabilities: Policy Directions for the States</i> (Feb. 1991) .....   | 23           |

|  |    |
|--|----|
| Barbara Wright, What Legislators Need to Know About Mental Retardation and Developmental Disabilities, National Conference of State Legislatures (Feb. 1990) ..... | 20 |
|--|----|

## INTEREST OF AMICI CURIAE<sup>1</sup>

The National Mental Health Consumers' Self-Help Clearinghouse is a national technical assistance center established in 1986. It is run by and for people who are consumers of mental health services and survivors of psychiatric illness (known as consumers/survivors). Its mission is to promote consumer/survivor participation in planning, providing and evaluating mental health and community support services, to provide technical assistance and information to consumers/survivors interested in developing self-help services, and advocating to make traditional services more consumer/survivor-oriented. As with all of the other amici, the Clearinghouse has an interest in helping people with mental illness live to their full potential as active members of the community.

The Alaska Mental Health Consumer Web is a resource for mental health consumers. All of its efforts are aimed at promoting recovery. Among its many activities, the group organizes consumer support groups, has been effective in changing mental health policy, and fights the stigma of mental illness through information and education.

C.H.O.I.C.E.S. in Georgia (Consumers Helping Ourselves with Information, Communication, Empowerment and Support) is an advocacy organization of consumers/survivors dedicated to ensuring consumer choice. Its current initiatives include working to promote (1) the establishment of extensive and varied community resources and services, especially

---

<sup>1</sup> The parties have consented to the filing of this brief under S.Ct. R. 37.2, and their letters of consent have been lodged with the Clerk of the Court. Pursuant to S.Ct. R. 37.6, amici state that counsel for a party did not author this brief in whole or part and that no one other than amici, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.



peer-run services; (2) the use and acceptance of advance directives; (3) early intervention in helping people diagnosed with mental illness and in providing them with information and options; and (4) societal understanding and acceptance of diversity.

Contac is a national technical assistance and resource center for consumers/survivors and consumer-run organizations across the United States, promoting self-help, recovery and empowerment. Contac was developed utilizing research on ideal consumer self-help programs, successful consumer-run programs, community support service philosophy about service delivery, descriptions of mature mental health systems, and management and leadership skills.

The Madness Group operates a decentralized electronic forum and distribution device for exchanging information about methods for advocating social change. The group also distributes resources of use to people who have psychiatric histories.

The Mental Health Empowerment Project, Inc., is a not-for-profit corporation that starts self-help and advocacy groups for mental health consumers and provides training in psychiatric rehabilitation. It operates in several states with state contracts or managed care public sector contracts.

Pennsylvania Protection and Advocacy, Inc., is the Governor's designated protection and advocacy system for persons with mental illness. The majority of its Mental Health Advisory Board members are individuals who have experienced both institutional and community-based mental health services, as have members of its Governing Board.

Plusabilities is a Georgia-based consumer/survivor-owned and -operated business. Plusabilities contracts with public mental health/mental retardation/substance abuse agencies to conduct consumer and family satisfaction/service evaluation/outcome measurement surveys, and provide peer

support to consumers/survivors moving into the community from hospitals or other congregate settings.

United Self-Help is a consumer group in Hawaii that works to keep people out of the hospital by promoting attendance at support groups. Its members support the concept that community-based services, including peer-run services, are the most effective way to promote recovery in people with mental illness.

Well Mind Association of Minnesota's mission is to expand treatment options for people diagnosed with mental illness, to provide information about integrative health care for these individuals, and to encourage their self-empowerment.

Sally Clay is an individual who has experienced manic-depressive episodes (including some 19 hospitalizations) since 1962, and has worked as a peer organizer and advocate for over 18 years. She is currently working as a systems manager or peer consultant with two grants from the Substance Abuse and Mental Health Services Administration, one for Consumer-Operated Services and one for Women and Violence. She credits her recovery to the services and supports she has received in the community.

Margaret M. Geary, J.D., a mental health consumer, is a Massachusetts attorney and member of the Supreme Court bar practicing in the area of mental health law. She has represented many people who have been committed to state institutions and is a strong advocate of the position that people with mental illness can be served most effectively in the community.

Steven LaMaster, M.S., is a rehabilitation practitioner for ResCare, Inc., an agency that provides psychiatric rehabilitation services, including a wide array of residential supports, to people who experience difficulties in living, learning, working, and socializing. The agency supports individuals'

right to self-determination regardless of the symptomatology that they experience.

Barbara Lee, Ph.D., is a consumer of mental health services and a clinical psychologist and policy and services researcher, working with people who also have experienced severe mental illness. As a professional, she has seen people who had spent long periods in institutions, with little or no progress there, make a successful transition to living in the community, with the appropriate services and supports.

Alexander R. McNaught was diagnosed with schizophrenia 22 years ago. Except for brief hospitalizations totaling two months, he has lived and continues to live successfully in the community.

Laura McRae, who has been repeatedly hospitalized for mental illness, lives and works in the community. She characterizes her hospital experience as "warehousing," with very little in the way of treatment or activities, and the absence of power over her own life.

David Shaver is executive director of Consumer Support Services (CSS), which operates a mental health community center, funded by the State of Florida Department of Children and Families and the City of Jacksonville. CSS has a membership of over 300 persons with mental illness, approximately 30 percent of whom have been long-term residents of state mental hospitals. CSS supports the development of community placements and supports for people in institutions.

Laura Van Tosh is a person with a psychiatric disability who has been institutionalized in the mental health system and has benefited from community-based programs. She has participated in psychosocial and vocational programs and has used the Americans with Disabilities Act to secure reasonable accommodations in employment. Ms. Van Tosh is now an advocate and a consultant in the health care field. She

credits her recovery to caring professionals, self-help, advances in treatment, and the opportunity to live in the community.

## SUMMARY OF ARGUMENT

This brief will examine the critical relationship between community services and the integration mandate at issue in this case. Amici are individuals and organizations of individuals who have experienced both institutional and community-based mental health services. Through some of our individual stories and supporting professional literature, we will document that community-based services provide myriad opportunities for interaction between people with and without disabilities, promote recovery, and lead to a more enjoyable, fulfilling life.

The state of Georgia and its amici argue that this Court should give discretion to the states to decide where and how to serve people with disabilities. They ignore, however, that their discretion can and has resulted in people with disabilities living under conditions of great and unnecessary restriction, with limited contact with non-disabled individuals and very little personal freedom for many years. Political pressure, bureaucratic inertia, job concerns of hospital employees, neighborhood resistance and other factors have too often taken precedence over the rights of people with disabilities who could be served in the community. This is particularly egregious given that community-based services are less expensive than institutional care.

The integration mandate of the Americans with Disabilities Act requires that people with disabilities be allowed the same freedoms that people without disabilities take for granted: the ability to see family, friends, neighbors and co-workers; to go to church, the movies, shopping, the library or simply to go outside; to hold a job, enjoy a hobby or



volunteer for a cause. It is these personal liberties that are at stake in this case.

We begin with personal accounts illustrating the benefits of living in the community as opposed to institutional care. It is important to note that none of the people whose stories are told below were released from an institution because they had "recovered." In every case—and this is typical of most people who have spent significant periods of time in an institution—they were released either due to changes in policy, or through their own efforts or those of their advocates.

After recounting these stories, we describe the array of services that may be found in a community-based mental health system. Not every person with a disability will need the same kinds of service. Each of the individuals whose lives we describe receive some of these services according to their needs. In this section of the brief, we give a more technical description of these services and conclude with a review of the professional literature confirming the benefits of integrated services.

## ARGUMENT

### I. PERSONAL ACCOUNTS OF THE BENEFITS OF INTEGRATED SERVICES

For someone who has never been in an institution, the stark contrast between community and institutional life is difficult to imagine. But those who tell their stories below, or whose stories are told by others, don't have to imagine; all have spent years living in institutions. Now, each is living successfully in the community. These stories are not atypical. They represent personal accounts of the well-documented positive outcomes of integration: the ability to be part of a community which includes people with and without disabilities; greatly increased fulfillment and productivity as workers and volunteers; and more rapid recovery as an individual

makes choices, learns skills in a natural environment such as a home or a workplace, and forms meaningful relationships.

#### A. Jane D.

Jane D., a woman in her fifties, had lived in the state hospital for many years. Jane experienced significant reductions in physical injury and neglect when she was discharged to a smaller, more integrated setting. Her recent discharge into the community radically improved her life.<sup>2</sup> According to her advocate,

this lady had taken so many falls in the state hospital and had broken her leg so many times, they thought they would have to amputate. She was incontinent and 'gray': she had gray hair, gray skin and a gray look. I never saw her move; she was parked in a chair all day, every day. She was locked in a dining room, and had no independent access to a bathroom. They had to sit in the locked room and wet themselves.<sup>3</sup>

When Jane was released into the community, it was thought that she had dementia, so she was at first placed in a restrictive program. However, very soon she was moved to an unlocked group home. After this transition, her advocate

did not recognize her when I went to visit her. She was outside, beautifully dressed, and she talked to me. In a year and a half [that I saw her] at the state hospital, she never talked. Now she was alert and lively. The staff said

<sup>2</sup> Telephone interview with Diana Carra Haugh, Advocacy Specialist, Pennsylvania Protection & Advocacy (February 11, 1999).

<sup>3</sup> *Id.*

she hasn't been incontinent since two weeks after she came here. Obviously she now lived in a place where she could get to the bathroom and had fun, interests, stimulation; she had decided to go on living. There were no more falls [because] her medication was drastically reduced. She likes to walk, she participates in church groups, she likes to go shopping. Her favorite thing is going to flea markets. She has friends. Try to picture a gray, quiet, frail woman who didn't engage or express anything. Now picture someone with a big smile, beautifully dressed, striding down the lawn.<sup>4</sup>

#### B. James Price

James Price, now in his mid-40s, spent much of his life in an institution, but now has achieved independence in his own apartment and fulfillment in volunteer activities and family relationships. Mr. Price spent 10 years of his youth in Pennhurst State School. Later, as an adult, he was in Norristown State Hospital for two or three years. He was subsequently admitted to Philadelphia State Hospital, and spent five or six years there. He described the conditions at the hospital. "It was hard living there," he recalled. "I had to stay in a day room and wasn't able to get out. We had a dormitory with eight to ten people. I got in trouble there a lot. They would put me in seclusion and restraints and give me needles."<sup>5</sup>

For the last eight years, however, he has lived in his own apartment in Philadelphia, and he enjoys his freedom. He worked for the Philadelphia Department of Sanitation for five

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<sup>4</sup> *Id.*

<sup>5</sup> Telephone interview with James Price (Feb. 9, 1999).

years. Now he lives off what he receives from Social Security Disability Insurance. He contrasts his life in the hospital to his current life in the community:

Now that I am out, I don't smoke or drink anymore. I go to Cocaine Anonymous meetings and serve coffee. I help out at Zion Baptist Church stuffing envelopes. A deacon gets me to help him move disabled people into apartments. I go to the park, do my own shopping and cooking. I see my mother, my brothers and sisters. I go to movies sometimes on Sundays with one of my friends. Sometimes my niece comes over and spends the night. She's eight or nine years old. I make sure she eats: I cook for her or take her to McDonald's or Burger King. That's fun.<sup>6</sup>

#### C. Michael J. Kennedy

Michael Kennedy's personal account reveals that institutions, in their isolation from public view and low staffing, tend to allow more abuse and neglect to continue. However, his story also shows the myriad of opportunities for a productive life in the community. He is married, owns his own home, and works as an advocate for people with disabilities at Syracuse University's Center on Human Policy.<sup>7</sup>

Born with cerebral palsy, Mr. Kennedy was placed in an institution in New York State at the age of five. He was transferred from there to another institution, and from there to a third. He finally won his release when he was 21.

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<sup>6</sup> *Id.*

<sup>7</sup> Telephone interview with Michael Kennedy (Feb. 11, 1999).



His years in the institution were marked by neglect. He attended a segregated school on the grounds of the state institution where

all we did was watch 'Sesame Street' on TV every morning. We put pegs in a peg board for the other half of the morning. Then we went to lunch, and then we took naps until it was time to go back to the unit. When I outgrew my braces, they took them away and never ordered me any more. My mother used to give me physical therapy at home; they stopped that, as a punishment.<sup>8</sup>

As a result of his educational neglect, he had no formal education; he went back and got his General Equivalency Diploma when he was 32 years old. He further describes very poor conditions in the hospital:

The hallways of the institution were dark and dingy. It smelled like urine and feces; although you didn't see any, it smelled like it because it was embedded in the tiles and the floor. People would lay around naked half the time. The staff members who cared didn't stay for very long. They couldn't stay and watch what was going on, which included the use of cattle prods and ammonia sprayed in the eyes as punishment.<sup>9</sup>

After many years in institutions, Mr. Kennedy heard about a supported apartment program and advocated to receive services in the community. In an article about his experiences, he wrote, "What I liked most was that the apart-

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

ment was in the community. I was viewed as belonging to the community and could experience being around people without disabilities."<sup>10</sup>

Michael Kennedy is one of many individuals who have spent significant periods of their lives in institutions and who was able to make a successful transition back to the community. His life now has much in common with the lives of his neighbors.

My wife and I both work; we are very active members of our community and our church. My wife has cerebral palsy as well; she also uses a wheelchair. She's a vocational rehabilitation specialist.

We're very well known and respected in our neighborhood. We enjoy going away on vacation, we go to movies, we do the same things anyone would do. In an institution, you didn't get those luxuries. If you did get to go out of the institution, you went in groups. You couldn't even strike up a relationship if you wanted to. Freedom means a lot—that I am somebody regardless of what my limitations are. What I advocate for is that people like me can live a normal life, regardless of their disability. Part of my job is to make sure that they get a fair shot.<sup>11</sup>

<sup>10</sup> Michael J. Kennedy, *Turning the Pages of Life* in J.A. Racino, et. al., *HOUSING, SUPPORT, AND COMMUNITY: CHOICES AND STRATEGIES FOR ADULTS WITH DISABILITIES* 206 (1993).

<sup>11</sup> Telephone interview with Michael Kennedy (Feb. 11, 1999).

#### D. Bernie S.

Bernie's living situation perhaps best illustrates the difference between a hospital and a home. At age 21, Bernie started hearing voices. His parents took him to a psychiatrist who diagnosed him with paranoid schizophrenia and strongly advised that he be institutionalized. After a year and a half at the Institute of Pennsylvania Hospital, when his insurance ran out, he was transferred to Haverford State Hospital, where he stayed 22 years.<sup>12</sup>

Bernie moved into a supervised group home in June 1998. He lives with four other men in a small white house run by Elwyn Institute, in Elwyn, Pennsylvania. There are several staff during the day and one person who remains on duty during the night after 11 pm. His mother explains the change in his opportunities and life as follows:

They live in a family atmosphere; it's not institutionalized. Bernie and the other residents cook together; they help the staff to prepare meals; they buy their groceries. The staff and the residents sit at the dining room table and eat their meals together. They watch T.V. in the living room or play games—Trivial Pursuit, Monopoly, you name it. Each person has his own room. They have learned to wash and dry their own clothes .... It is not the same to live in a hospital as to live in a house surrounded by beautiful grounds, and flowers, which they take care of. They live their lives

<sup>12</sup> Telephone interview with Aimee S., mother of Bernie S. (Feb. 11, 1999).

like I live my life. I couldn't ask for anything better.<sup>13</sup>

Like many of the others described herein, Bernie now participates in numerous activities that enrich his life and allow him to interact with people without disabilities. For example, he goes on trips to attractions such as the Arboretum, Ridley Park and the Philadelphia Museum of Art; an instructor teaches him T'ai Chi and a pastor comes every two weeks to talk to him and other residents. Most importantly, Bernie has begun initiating conversations. For 22 years in the hospital, he talked very little, if at all. Now, when he and his mother go to a restaurant, he will comment if she is not eating. Recently, his mother noted that Bernie had spontaneously commented that she had cut her hair. In her words, "I almost dropped dead. That's something he would not even mention before. Now he is much more alert to the environment because the staff is constantly stimulating him and the other residents."<sup>14</sup> The small ratio of staff to resident allows for more innovative programs and good guidance. Their assistance has led to an enormous difference in his quality of life and ability to socialize with other people.

<sup>13</sup> *Id.* A similar account can be found in the non-fiction book written by reporter Michael Winerip, who followed the lives of residents of a mental health group home in Glen Cove, New York. One of the residents, Fred Grasso, had schizophrenia and had been living in a two-hundred-bed facility which had been cited for numerous health and safety violations. His mother expressed her great relief at the lovely group home, which had a living room with a fireplace, a dining room, bedrooms and a well-stocked kitchen. M. Winerip, 9 HIGHLAND ROAD 72-74; 101-104 (1994). "You don't know what this means to me," Mrs. Grasso said, her eyes filling with tears once more. "You don't know." *Id.* at 74.

<sup>14</sup> Telephone interview with Aimee S., mother of Bernie S. (Feb. 11, 1999).



### E. Margaret Donahue

Margaret Donahue describes the increased privacy, opportunity for making her own choices and reduction of symptoms that occurred when she was provided with integrated services in the community.<sup>15</sup>

Ms. Donahue, who is diagnosed with schizophrenia, spent most of her life in institutions. These include Philadelphia State Hospital and Norristown State Hospital. She now lives in Willow Grove, Pennsylvania, in a house she shares with two other women, both of whom were also patients at the state hospital. The house is a "supported living" residence, with round-the-clock staffing.

She has her own bedroom, and relishes her privacy. In her words:

There's a lot of things you can do living in the community, like go up to your room if you want to be by yourself. In the hospital, there were a lot of people. We had dormitories, six people in each.<sup>16</sup>

She has also experienced a reduction in her symptoms and, thus, freedom from restrictive and sometimes painful measures such as physical restraints. In the hospital, she reported, she spent a lot of her time in restraints because of

<sup>15</sup> Telephone interview with Margaret Donahue (Feb. 10, 1999).

<sup>16</sup> *Id.* The indignities and lack of privacy in the hospital are also documented in an autobiography by Professor of Psychology Kay Redfield Jamison. K. Jamison, *AN UNQUIET MIND* (1995). She writes, "My psychiatrist repeatedly tried to persuade me to go into a psychiatric hospital, but I refused. I was horrified at the thought of being locked up; being away from familiar surroundings; having to attend group therapy meetings; and having to put up with all the indignities and invasions of privacy that go into being on a psychiatric ward." *Id.* at 112.

fighting and banging her head. In the community, she has none of those problems. She entertains visitors, and sometimes goes to church. She also does her own housework, and has a part-time job cleaning houses. In her own words:

It's better living in my house [than in the hospital] .... It's much better, because you have staff 24 hours a day like in the hospital but you can go to the bank, shopping, or Rite-Aid. It's better out here. It feels like you're in your normal home. You can't live in the hospital all your life.<sup>17</sup>

Asked to name the main advantage of life in the community over life in the hospital, she responded, "I like having the power over my own life."<sup>18</sup>

### F. Charles Q.

Charles Q. experienced a drastic change in his daily routine when he began to receive community services. Charles was a patient in a Pennsylvania state hospital for some 40 years. Charles has mental retardation and, according to advocates who helped secure his release into the community, he entered the hospital after an extended period of living in a car.<sup>19</sup>

Hospital staff administered large doses of the medication Thorazine, which had an adverse affect on his ability to communicate. After a year in the hospital, he became incontinent and nonverbal. He was eventually transferred to a

<sup>17</sup> Telephone interview with Margaret Donahue (Feb. 10, 1999).

<sup>18</sup> *Id.*

<sup>19</sup> Telephone interview with Diana Carra Haugh, Advocacy Specialist at Pennsylvania Protection and Advocacy, Inc. (February 11, 1999).

back ward. There is very little in the files over the years about what happened to him. Advocates discovered him in a geriatric ward of the state hospital.<sup>20</sup>

According to one of his advocates, Charles "had almost no speech, just a few repetitive phrases. He paced constantly, and was not engaged in any meaningful activity. He didn't have a lot of attachments to anyone there."<sup>21</sup> Charles' daytime activities were routine and unchanging for most of the forty years he spent in the hospital. Each day, Charles would

...get up about 6 or 6:30 in the morning, get dressed, stand in line for medications for 20 minutes or a half hour, and have his breakfast tray brought to the unit. Then he would begin to pace the halls. He might go outside: they were allowed to go outside, if the weather was good, twice a day to smoke a cigarette, sitting on a bench behind the building. Then he would have lunch, on a tray brought to the unit. The afternoon again would be spent pacing the halls, watching TV, sitting somewhere.... At 4 or 4:30 p.m. a tray of dinner, then pacing the halls, watching TV, sitting in a corner of the room not doing much of anything. Then at 6 or 7 p.m. he'd take a shower, pace the halls and then go to bed.

Once in a while recreation would come in and he would agree to take a van ride, and come back. They wouldn't go anywhere, just in the

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<sup>20</sup> *Id.*

<sup>21</sup> Telephone interview with Jacqueline Beilharz, Supervisor, Pennsylvania Protection and Advocacy (February 11, 1999).

van to ride around for a while, and drive back to the hospital. His only other contact with the outside world was his sister, who would visit occasionally.<sup>22</sup>

In 1997, Charles was released into the community. He is now living in a group home with three other residents. Staff members help him and the other residents learn "daily living" skills while doing for them the things they have not yet learned to do.

The staff have spent a lot of time helping Charles reintegrate into the community, including going to the grocery store, clothes shopping, the movies, the library—things we all do every day but that he hadn't had a chance to do in 40 years. Charles particularly likes to go to the library. For years, no one knew he could read, but he enjoys reading. He is also fully involved in the daily life of his home. He helps cook dinner, and is learning to use the microwave. He can already use all the other appliances. He goes grocery shopping, and is learning to do his laundry. He enjoys music, talking with staff, leisurely strolls around the neighborhood, and various other recreational activities, such as going to parks, restaurants, playing bingo and Jenga.

Most importantly, Charles is now actively participating in his treatment meetings. He shares his preferences, stating the things he likes and does not like to do. By interacting with people in the community, Charles has learned not to swear or tell people to get away from him. He has progressed rapidly in the most integrated setting appropriate for him.<sup>23</sup>

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<sup>22</sup> *Id.*

<sup>23</sup> *Id.*



## II. COMMUNITY-BASED SERVICES ALLOW PEOPLE WITH DISABILITIES TO OBTAIN THE MAXIMUM INDEPENDENCE AND INTEGRATION WHILE RECEIVING TREATMENT AND SUPPORT

As the stories above demonstrate, an array of community-based services is necessary to serve people with disabilities in the most integrated setting appropriate to their needs. Not every person with a disability will need all services. Generally, the individual with a disability and their treating professionals create a service plan that is designed to meet the person's needs. Each of the individuals discussed above uses a subset of services.

In contrast to the institution, a much wider variety of services and creativity is possible in the community due to increased staff and many more opportunities for learning through work, volunteering, and community activities. The institution, which is designed for congregate care of large numbers of individuals by smaller staff, is ill equipped to individualize services and provide opportunities for growth. Moreover, these higher quality community-based services are more cost-effective than institutional care because they do not require large overhead costs and people only use what they need.<sup>24</sup>

<sup>24</sup> See Aileen Rothbard, et al., *Service Utilization and Cost of Community Care for Discharged State Hospital Patients: A Three-Year Follow Up Study*, American Journal of Psychiatry, December 9, 1998, at 2, 16 (study of 321 people who were moved to the community from the institution concluded that community-based treatment cost 50% less than institutional care); Richard D. Budson, M.D., *Community Residential and Partial Hospital Care: Low-Cost Alternative Systems in the Spectrum of Care*, 65 PSYCH. QUARTERLY 209 (1994) (in Massachusetts program, per diem costs of each alternative in continuum of community-based services were significantly less than those in inpatient unit, with the most costly community alternative being less than half as costly as hospitalization).

In this section, we describe the array of services in a community-based system of care, rather than an institutional one. We describe general categories of services and then give specific examples. It should be noted that although the categories are general, there is sometimes different terminology to indicate the same service. For example, in some systems, a case manager is referred to as a service coordinator. Here, we give the most common categories and the definitions to explain what we mean by a community-based mental health service system. The institutions that we have experienced typically have a much smaller array of services, often limited to infrequent group or individual therapy and restricted recreational activities (such as a van ride that does not allow us to leave the van or board and card games).

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Costs in community treatment facilities were kept down through staffing patterns that maximized care while minimizing costs, and due to the lack of administrative overhead required in hospital setting); Herbert Bengelsdorf, M.D. et al., *The Cost Effectiveness of Crisis Intervention: Admission Diversion Savings Can Offset the High Cost of Service*, 181 J. NERVOUS & MENTAL DISEASE 757 (1993) (documenting considerable cost savings achieved by using crisis intervention services and other community-based services for individuals who otherwise would have been hospitalized).

## A. A Community-Based Mental Health System<sup>25</sup>

**1. Treatment:** Treatment services are both diagnostic and therapeutic. Generally, they are provided by professionals or trained personnel to evaluate the nature and extent of an individual's disability and to provide help with learning about and coping with the disability. Treatment services may be provided by an individual or as part of a team process.

A list of potential treatment services may include: 1) intake screening, comprehensive evaluation/assessment and treatment planning; 2) medication therapy and monitoring; 3) outpatient counseling (individual, family and group counseling); 4) mobile community outreach and treatment; 5) crisis intervention and stabilization; 6) intensive day treatment; 7) assistive technology.

**2. Residential services:** Supportive services can be provided as a complement or as part of a range of housing options. Such services should be flexible, increasing or decreasing in intensity based on the individual's needs. Minor home or environmental modifications or adaptive equipment

<sup>25</sup> See Center for Mental Health Services, *Mental Health Directory 1995* at vii-ix (listing mental health organizations and program elements); "A Service Development Plan for a Comprehensive System of Public Mental Health Care in Compliance with the Orders of the Court in *Dixon v. Sullivan and Dixon*," July 1991 (Approved and ordered on January 27, 1992, U.S.D.C. for the District of Columbia, Civil Action 74-285 (AR)); Barbara Wright, *What Legislators Need to Know About Mental Retardation and Developmental Disabilities*, National Conference of State Legislatures (Feb. 1990); State of Alabama, Department of Mental Health and Mental Retardation *Five Year Plan FY 93-94 to FY 97-98* at 46-51; K. Charlie Lakin and Mary Hayden, *Final Report to the Health Care Financing Administration: An Evaluation of Implementation of the Medicaid Community Supported Living Arrangements (CSLA) Program in Eight States 22-23* (1996); Beth Stroul, *Crisis Residential Services in a Community Support System: Report on the NIMH Crisis Residential Services Project 6-10* (1987).

can be used to improve a person's residence to allow for community living, safety, security and accessibility.

Some residential options include: 1) group homes; 2) independent apartments; 3) family or foster (also known as family care) homes; 4) semi-independent apartments; 5) board and care residences.

**3. Rehabilitation services:** Rehabilitation Services are therapeutic activities designed to improve living skills and to assist the person with a disability in realizing their potential for independence and for useful and productive activity, such as work.

Rehabilitation Services include: 1) day programs; 2) psychosocial rehabilitation; 3) educational services; 4) prevocational services; 5) work adjustment training; 6) supported work and transitional employment programs.

**4. Support Services:** Support services assist the person with a disability in their daily life. They are often used to ensure that people with disabilities can access resources such as entitlement benefits, medical care and related services. These services also can assist a person in developing relationships key to their success and stability in community living. Case management services, in particular, are important in a helping to create an integrated set of services from an often otherwise fragmented array of state and local resources. Support Services include: 1) case management; 2) intensive case management; 3) family supports; 4) social clubs; 5) advocacy; 6) personal care/home health aide; 7) homemaker and chore services; 8) peer support/self-help group; 9) respite care.

As previously noted, a plan is created from the array of services. For example, named plaintiff L.C. receives several community services to meet her needs. L.C. resides at Nyasha House, a group home which provides intensive support and trained staff who counsel L.C. when she becomes frus-



trated. Staff have found innovative ways to help her deal with these feelings. L.C. also receives psychotropic medications daily. On Monday, Wednesday, and Friday mornings, she attends Community Friendship, which is a day program where she has been receiving educational services and has worked in a supported environment. She has made frequent trips to the library and the homes of staff, and has had other opportunities to interact with the community.<sup>26</sup>

### III. THE PROFESSIONAL LITERATURE CONFIRMS THAT COMMUNITY-BASED MENTAL HEALTH SERVICES ALLOW FOR MORE SOCIAL INTERACTION WITH NON- DISABLED PEOPLE, BETTER RECOVERY, AND GREATER HAPPINESS AND FULFILLMENT.

The professional literature establishes that individuals such as L.C. and those whose stories are told above achieve better outcomes in the community. First, professional literature reflects the view that providing services in community settings is critical to fostering social integration because such settings provide opportunities for individuals with disabilities to develop social relationships and to engage in activities with people without disabilities. These opportunities cannot arise in an institutional setting. Dr. William A. Anthony, Executive Director of the Center for Psychiatric Rehabilitation at Boston University, notes that:

[To achieve] recovery, people need to learn new skills and be provided with appropriate supports. The hospital setting impedes the learning of skills that are needed in the community and, by definition, the community

<sup>26</sup> Elliot eval., Exh. 14, R59 (Plaintiffs' Statement of Material Facts with Motion for Summary Judgement, filed 8/19/96).

supports that are needed can't be provided within the hospital. These community supports are essentially people, places, things, and activities . . . .<sup>27</sup>

In addition, community services are virtually always more effective than institutional services in terms of outcomes achieved. Studies show that non-institutional care had better outcomes in almost every case concerning employment, school attendance, and other factors.<sup>28</sup> In addition, in-

<sup>27</sup> Telephone interview with William A. Anthony, Ph.D. (Feb. 25, 1999). See also William A. Anthony, *Recovery from Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s*, 16 PSYCHOSOCIAL REHABILITATION J., APRIL 1993, at 11 (mental health recovery requires not just mental health services but other activities such as participation in sports, clubs, adult education, and church activities); Barbara Wright & Martha P. King, National Conference of State Legislatures, *Americans with Developmental Disabilities: Policy Directions for the States* 21 (Feb. 1991) (community living benefits individuals with disabilities by permitting increased independence, sense of competence, improved relationships with family and friends, and increased respect, dignity, and sense of belonging); Paul J. Carling, RETURN TO COMMUNITY: BUILDING SUPPORT SYSTEMS FOR PEOPLE WITH PSYCHIATRIC DISABILITIES 255 (1995) (providing supportive services within integrated community settings and ensuring that consumers have opportunities to engage in "normal" social interactions enhance social integration); Zana Marie Lutfiyya, Center on Human Policy, *Reflections on Relationships between People with Disabilities and Typical People* (Aug. 1988) (enforced segregation in large congregate facilities reinforces the idea that people with disabilities are too "different" to contribute to society, and reduces opportunities for enhancing social integration through social relationships, diversity of social connections, and intimacy in relationships).

<sup>28</sup> A. Kiesler, *Mental Hospitals and Alternative Care: Noninstitutionalization as potential Public Policy for Mental Patients*, 37 AM. PSYCHOLOGIST 349, 357-58 (Apr. 1982).

dividuals discharged from state institutions show significantly improved functioning and behaviors.<sup>29</sup>

Finally, individuals who use mental health and mental retardation services overwhelmingly prefer community-based services to institutional services. As Dr. Anthony notes, "[t]he preference studies indicate that psychiatric patients prefer to live in the community rather than the hospital, so you have a much better motivational base for interventions, because the people are in the spot they prefer. It's hard to do helpful interventions when the person is not in the spot they wish to be in."<sup>30</sup>

<sup>29</sup> James Conroy et al., *A Matched Comparison of the Developmental Growth of Institutionalized and Deinstitutionalized Mentally Retarded Clients*, 86 AM. J. MENTAL DEFICIENCY 581 (1982) (individuals discharged from state institution to community placements showed significantly improved functioning and adaptive behavior after two years). Paul J. Carling, *Major Mental Illness, Housing, and Supports*, 45 AM. PSYCHOLOGIST 969, 971 (Aug. 1990) (studies indicate that "community-based treatment is virtually always as effective or more effective than hospital-based treatment in helping people with psychiatric disabilities to achieve employment outcomes, to gain re-entry into the community, and to reduce the use of medication and outpatient services.").

<sup>30</sup> Telephone interview with William A. Anthony, Ph.D. (Feb. 25, 1999). See also Aileen B. Rothbard & Eri Kuno, *The Success of Deinstitutionalization: Empirical Findings from Case Studies on State Hospital Closures*, J. INT'L LAW & PSYCHIATRY, January 28, 1999, at 3-4; Te-wei Hu & Jaclyn W. Hausman, Institute for Mental Health Services Research Working Paper No. 4-94, *Cost-Effectiveness of Community-Based Care for Individuals with Mental Health Problems* 26 (July 1994) (individuals in community-based programs reported higher satisfaction and improvement of quality of life); John Lord & Alison Pedlar, *Life in the Community: Four Years After the Closure of an Institution*, 29 MENTAL RETARDATION 213, 219 (1991) (virtually all individuals in study, who had been moved from institutional setting to group home four years earlier, were happier in community); Paul J. Carling, *Major Mental Illness, Housing, and Supports*, *supra*, at 971 (research indicates that people with

The professional literature reflects the conclusions of the stories herein and the experiences of amici. All people want to live in homes, to be productive and to engage in meaningful activity. When such opportunities are provided in community-based settings, individuals with disabilities achieve better outcomes, have more interaction with people who do not have disabilities, and are generally happier and more fulfilled.

## CONCLUSION

The people whose stories are told above are only a few of the individuals whose lives will be affected by the outcome of this case. The ruling in this case will determine whether the states can continue to segregate people in institutions—people who are capable of living successfully in the community—and to deprive them of the freedom to control their own lives. The ruling will also determine whether the Americans with Disabilities Act—the landmark civil rights statute for people with disabilities—gives people who have disabilities meaningful and equal opportunities in their daily lives, or whether these opportunities will be rationed. Finally, this case will decide whether a civil rights statute, similar in intent to the Voting Rights Act, the Fair Housing Act, and the Civil Rights Act of 1964, will be enforced equally across the country, or whether individual states can decide how many civil rights should be accorded to a minority population that has suffered historic discrimination.

In consideration of the serious issues at stake, this Court should affirm the Court of Appeals, on the ground that people with disabilities have a right to the same basic freedoms as all other citizens.

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psychiatric disabilities value independence and productivity more than any other treatment outcomes).



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Respectfully submitted,  
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